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CYST-WALL CALCIFICATION IN INTRACRANIAL CYSTICERCOSIS

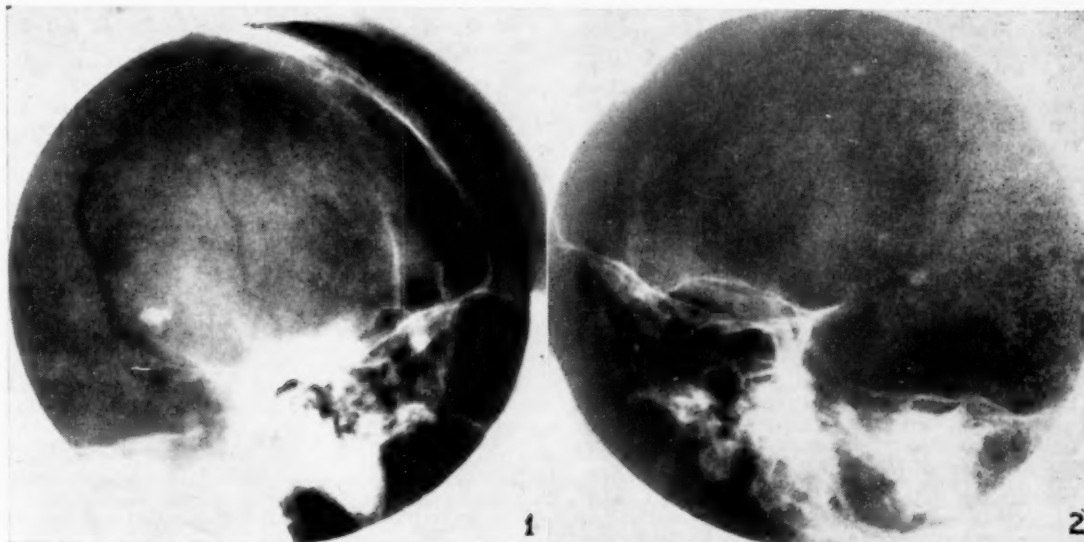
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Intracranial cysticercosis has long been recognized as a cause of intracerebral calcification and, although cysticercosis perhaps occurs intracerebrally as frequently as in muscles,¹ radiological demonstration of intracerebral manifestation may not be possible even 10 years after the demonstration of the cysticercus in muscles, and indeed 90% of all intracranial cases never show calcification.²

It has long been a subject of argument, however, whether the wall of the cyst calcifies or whether calcification is confined to the scolex. In muscle it is generally accepted that the wall calcifies, but numerous authorities have quoted and demonstrated cases of intracerebral cyst-wall calcification, whilst as many authorities have stated that only the scolex calcifies intracerebrally. Arano and Aserjo³ showed that, of 71 cases of calcification due to intracerebral cysticercosis, in 66 the scolices only were calcified, but in the remaining 5 the whole cyst wall had calcified. Dixon and Hargreaves⁴ demonstrated cases in which calcified scolices are separated from surrounding cyst-wall calcification by translucent 'halos'. Latham⁵

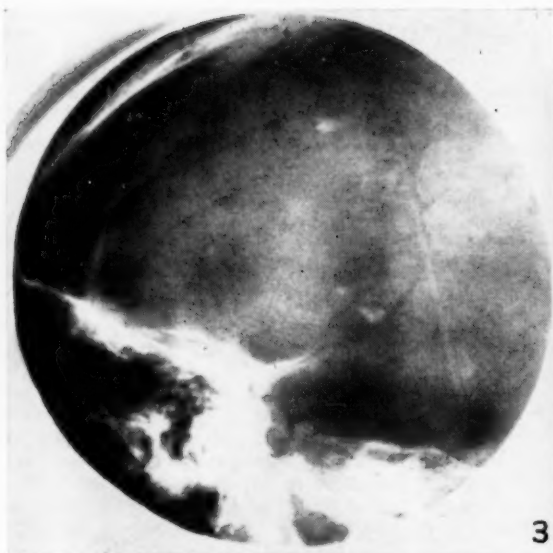
categorically states that 'brain cysts quite frequently calcify', and Kooy⁶ demonstrates a case of multilocular intracerebral cysts with linear calcifications throughout half the brain and it is obvious from the radiography that this calcification can only be in the cyst walls and not in the scolices.

However, most authorities state that only the scolex calcifies intracranially. MacArthur⁷ stated, 'When calcification results within the brain the parasite usually shows as small rounded shadows suggesting grains of shot'. This description of small shot-like punctate areas is obviously one of scolices only. Further, as late as 1955 Sutton⁸ dogmatically stated, 'The radiological features in the muscles are well known ... oat-shaped cysts ...' but he describes intracranial calcification as being 'different in nature ... small multiple discrete rounded nodules, 1-3 mm. in diameter. This is because in intracerebral cysts only the head of the scolex calcifies'. These and other authors who disbelieve previous demonstrations of intracerebral cyst-wall calcifications pass them over by naively suggesting that these



1. Right postero-anterior oblique view.

2. Left postero-anterior oblique view.



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3. Lateral view off-centred so that the opacities occupy centre of coned-down area.

4. Postero-anterior projection, nose-chin position.

demonstrations were in fact of calcifications in scalp muscles and not of intracerebral calcification.

In this article I submit a case of cysticercosis, confirmed on biopsy, in which by X-ray views in 4 different planes positive demonstration was obtained of intracerebral cyst-wall calcification.

CASE REPORT

An elderly female who was complaining of vague generalized body pains and especially acute pains in the shoulder joints was sent for X-rays of her lumbar, thoracic and cervical vertebrae and of her shoulder joints. In addition to vertebral osteophytosis and to osteo-arthritic changes in her shoulder joints, multiple oval or rounded opacities up to almost 1 cm. in length were found widely distributed in the soft tissues of the chest, abdomen, neck and upper limbs.

On being questioned the patient was found to have spent the greater part of her life in India. A diagnosis of cysticercosis was made.

Subsequently the patient returned complaining of headaches, which were especially severe retro-orbitally. Her skull was X-rayed and calcified areas identical in size, shape and appearance with the calcified cysts in the soft tissues were noted, and their intracerebral situation proved by the use of views of varying

obliquity (Figs. 1-4). In view of the presence of soft-tissue cysticercosis it was considered logical that the intracerebral calcifications could with reasonable certainty be labelled similarly.

SUMMARY

A case of proved intracerebral cysticercosis with definite radiological demonstration of cyst-wall calcification (a condition stated by some authorities not to exist) is presented, and the relative literature is summarized.

My thanks are extended to Dr. Josse Kaye, Chief Radiologist, Johannesburg General Hospital, for his advice and encouragement. I am also extremely grateful to Miss M. Tompkins for the photography.

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FACTOR VII

It is a curious fact that the serum which remains after blood has clotted is rich in coagulation factors. This was noted in 1912 by Bordet and De Lange¹ who collected bird and rabbit blood which was relatively free of contamination with tissue juice or platelets. The blood clotted slowly and the serum contained large amounts of prothrombin. Addition of platelet extract at this stage yielded thrombin more rapidly than in the corresponding plasma. In 1924 Schofield² found that a haemorrhagic disease of cattle resulting from inclusion of spoiled sweet clover (which contains dicoumarol) in the fodder could be helped by the injection into the animal of normal serum. Owen and Bollman³ showed that the prolonged one-stage prothrombin time of the plasma of dogs treated with dicoumarol could be corrected *in vitro* by the addition of a small amount of normal serum. Jacox⁴ showed that the coagulant activity of brain extract was increased by incubation of the extract with normal serum. From these and other observations it became obvious that serum contained a factor or factors active in prothrombin conversion. This 'factor' has been given a bewildering variety of names, e.g. prothrombin conversion factor, serum prothrombin conversion accelerator (SPCA), co-thromboplastin, convertin, stable component, factor VII and others. We propose to use the term factor VII to refer to this factor and to its possible plasma precursor. As several of its names indicate, this factor seems to be of importance in the conversion of prothrombin to thrombin. In addition to this factor, serum also contains another factor—Christmas factor. This is best shown by the thromboplastin-generation test of Biggs and Douglas.⁵ This factor is missing in serum from patients with Christmas disease and is present in patients with haemophilia.

Quick's one-stage test for 'prothrombin efficiency' is widely used in the control of anticoagulant therapy. Two rare causes of abnormality of this test are fibrinogen deficiency and the presence of inhibitors, such as heparin, in the plasma. In most cases the cause of the long one-stage prothrombin time is a deficiency of one or more members of the 'prothrombin complex'. These are factors V and VII and prothrombin. Factor-V deficiency is only rarely encountered, while deficiency of factor VII and prothrombin deficiency are much commoner. Serum contains little if any prothrombin or factor V since they are consumed during clotting of the blood. If the long one-stage prothrombin time is shortened by the addition of normal serum, then it is probable that factor VII is a missing factor in the plasma. Plasma treated by adsorption with aluminium hydroxide or barium sulphate contains little or no prothrombin or factor VII and will usually not shorten the prolonged one-stage time of this type of plasma. Patients on anticoagulant therapy (dicoumarol or phenindione) have a prolonged one-stage prothrombin time due to a combined deficiency of prothrombin and factor VII. Patients with obstructive jaundice, steatorrhoea or liver disease commonly

have defects of this type, while similar varieties may occur spontaneously in patients presenting as 'bleeders' since birth—so-called 'idiopathic hypoprothrombinaemia' or 'congenital factor-VII deficiency'.

Study of all these varieties of bloods has shown that the picture is even more complicated than was at first realized. In 1953 Biggs, Douglas and Macfarlane⁶ tested the serum of patients treated with the coumarin drug tromexan, and found all samples gave abnormal results when used to replace normal serum in the thromboplastin-generation test. They concluded that factor VII was necessary for thromboplastin generation. This conclusion was made questionable by the findings that serum samples from certain patients with congenital factor-VII deficiency (as judged by one-stage prothrombin-time tests) have normal thromboplastin formation⁷⁻⁹ and that the defect caused by the coumarin drugs is very complex, many possible factors being involved. It has been suggested that in addition to factor VII a new factor (factor X^{10,11}) and even Christmas factor^{8,9,12} may be deficient in these cases. Biggs⁶ and Greig and Tattersall¹³ also presented evidence that there seemed to be at least 3 coagulation factors present in normal serum.

Some of the differences encountered by various workers have been resolved by the finding that sera from patients treated with different coumarin drugs have different levels of Christmas factor: Tromexan causes a rapid and marked fall in Christmas factor whereas dindevan and possibly marcoumar have much less effect on Christmas factor. In mild cases of obstructive jaundice and/or vitamin-K deficiency, Christmas factor may be little affected, whereas it is sometimes markedly reduced in severely affected cases.⁹

The picture became even more confused when it was found that blood specimens from patients with 'congenital factor VII' deficiency were, in some cases, mutually correctable, thus also implying the presence of an additional factor.¹⁴ There are apparently 2 groups of cases both presenting with a long one-stage prothrombin time (when brain thromboplastin was used) correctable by normal serum,¹⁵ viz.:

Type A (pure factor-VII deficiency). Here there is (1) normal thromboplastin generation and (2) normal one-stage prothrombin time with Russell viper venom (stypven) instead of brain thromboplastin in the Quick test.

Type B (deficiency of the so-called 'Stuart-Prower' factor, which is probably identical with Koller's factor X). These cases have (1) abnormal thromboplastin generation and (2) abnormal one-stage prothrombin time with stypven.

By electrophoresis of human serum Bergsagel¹⁶ and Denson¹⁵ showed that factor VII migrated with the β globulins (as Christmas factor did) while the 'Stuart-Prower' factor migrated with the α globulin, thus confirming the presence of at least 3 factors in serum. Some patients were found belonging to type A, some to type B, while some lack both factors. The original case of 'Prower' defect apparently lacks both 'Stuart-Prower' factor and factor VII!

It is possible also that these defects may even occur together with other varieties of bleeding disorder.⁹

These findings help to explain some of the findings in the sera of patients on anticoagulant therapy. Not only is the type of drug used important but a time factor is also involved. The defects which arise appear to be as follows: (1) In the first few days of treatment a reduction in factor VII only, which is associated with a fall in the one-stage prothrombin time if brain thromboplastin is used but not

In the following table a summary is given of some of the facts presented above:

Test	'Factor-VII' deficiency		Christmas-factor deficiency	Anticoagulant therapy	
	Factor VII defect	'Stuart-Prower' defect		Early	Late
One-stage prothrombin time (Quick's test)					
(a) With brain thromboplastin	Abnormal	Abnormal	Normal	Abnormal	Abnormal
(b) With Russell viper venom (stypven)	Normal	Abnormal	Normal	Normal	Abnormal
Thromboplastin generation test	Normal	Abnormal	Abnormal	Usually normal but sometimes abnormal	Abnormal

BEGINSELS BY DIE GENEESKUNDIGE OPLEIDING

Gedurende die laaste aantal jare word die beginsels wat aan die grond van die geneeskundige opleiding lê, en behoort te lê, dwarsoor die wêreld druk bespreek. Die struktuur van die mediese kennis het oor die afgelope aantal jare onerkenbaar verander. Daarby het ook die patroon van ons gemeenskapslewe 'n radikale verandering ondergaan. In die lig van hierdie feite word dit allerweë gevoel dat die beginsels van mediese opleiding en onderrig ook in wesenlike heroorweging geneem moet word.

Ook in ons land het die nuwe rigtings en beklemtonings neerslag gevind. Aan ons ouere, gevestigde mediese skole het al meer stemme oor die vereistes van die omvattende medisyne opgegaan. En omdat daar beleidsbesluite oor die doelstellinge en metodes van onderrig aan ons jongere mediese skole geneem moes word, is dit veral hier waar ons die stemme sterk en duidelik verneem het. So het prof. H. B. Thom byvoorbeeld, Rektor van die Universiteit van Stellenbosch, in die *Tydskrif* van 24 Maart 1956 'n volledige uiteensetting gegee van hierdie nuwe benadering soos hy dit in Kanada en Brittanje teengekom het en soos hy dit graag aan die mediese skool te Stellenbosch toegepas sou wou sien. Die mediese skool van die Universiteit van Natal het reeds al ver gevorder—miskien verder as enige ander mediese skool—in die toepassing van die basiese beginsels van hierdie nuwe benadering. En elders in hierdie uitgawe van die *Tydskrif* plaas ons 'n onlangse lesing van prof. H. W. Snyman, hoof van die departement van interne geneeskunde van die Universiteit van Pretoria, waarin aangetoon word dat die nuwe benadering ook op Pretoria wortel geskiet het. Wat is nou die essensie van die nuwe benadering? Ons sou dit baie kortliks en sketsmatig in die volgende punte kon opsom:

1. *Omvattende medisyne.* Dit word gevoel dat die geneeskundige onderwys al meer los geraak het van die samelewing aan die een kant en van die kulturele universiteit

if stypven is used as a thromboplastin. (2) Later 'Stuart-Prower' factor is reduced, and Christmas factor also.

In 'dindevan plasma', therefore, a mixed variety of defect occurs, depending on the duration and intensity of therapy. The whole subject is a complex one but it does seem as if there are at least 3 factors in serum which affect blood coagulation, viz. Christmas factor and two others in the 'factor-VII' group—one of these might be called factor VII and the other 'Stuart-Prower' factor—the last name, incidentally, being derived from the surnames of the patients presenting with the disease, and not from the investigators.

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aan die anderkant—dat die mediese opleiding byna te veel tegniese opleiding geword het. Die punt is dat die menslike opvatting gevaar geloop het om deur kliniese oorwegings volstreke oorskadu te word. Die pasiënt met al sy behoeftes as mens moet net so belangrik bly soos sy siekte; trouens, sukses by die behandeling van sy siekte staan dikwels in noue verband met die suksesvolle hantering van die pasiënt as mens. Daarom moet die mediese opleiding hiermee rekening hou.

2. *Gesinsversorging.* Die opvatting dat gesinsversorging altyd 'n groot deel moet bly uitmaak van die hantering en behandeling van siek mense is reeds al oud, maar dit word nou weer orals opnuut beklemtoon. Die pasiënte wat vir mediese onderwys die kliniese materiaal moet uitmaak, is nie net in opleidingshospitale te vinde nie. Studente moet, saam met maatskaplike werkers, 'n groter insae kry in die totale agtergrond van hulle pasiënte. Eintlik is dit weer die benadering en gesindheid wat hier van oorwegende belang is, nl. dat die mens, en nie net sy siekte nie, in gedagte gehou moet word.

3. *Koördinerings van leergange.* Dit word al meer gevoel dat die basiese vakke van die medisyne nie in waterdige kompartemente gedoseer kan word nie, maar dat hulle telkens sover moontlik gekoördineer en geïntegreer moet word en dat onderrig in die medisyne al meer om die funksie van die orgaan, maar veral van die hele mens moet wentel.

4. *Etiologie van siekte.* Anders as by die benadering van die verlede, het die opvatting van die enkelvoudige veroorsaking van siekte nou plek gemaak vir die opvatting van meervoudige veroorsaking. Daar is nooit net een oorsaak van 'n siekte nie, daar is gewoonlik verskeie oorsake en dikwels baie. By beskouing van hierdie nuwe opvatting van die veroorsaking van siekte speel oorwegings aangaande die voorkoming van siekte en die voorbehoedende medisyne 'n groot rol.

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Om saam te vat sou ons kon sê dat hierdie nuwe beklemtonings in werklikheid beteken dat suksesvolle mediese praktyk in die moderne wêreld nie net die toepassing van tegnies-wetenskaplike beginsels behels nie, maar dat dit ook 'n kuns is wat met oorleg en op die basis van 'n gesonde lewensuitkyk en idealisme uitgeoefen behoort te word. Die feit dat die mediese praktyk ook en veral 'n lewenskuns is, maak dit egter nie minder noodsaaklik vir die dokter

om sy basiese wetenskaplike en kliniese kennis suiwer en grondig te verkry en te bewaar nie. Trouens, omrede van die snelle en geweldige uitbreiding van die aard en omvang van die mediese kennis, word volgehoue nagraadse opvoeding al meer 'n groot morele verpligting vir die dokter. Elke dokter moet gedurig bly leer sodat sy pasiënte gelukkig kan bly lewe.

THE EFFECT OF POLYCLINIC SERVICES IN A LOWER INCOME GROUP COMMUNITY

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The hospital is the centre of curative medicine, requiring comprehensive facilities for specialized staff and complicated equipment. The cost load of these facilities makes it advisable to centralize them in the larger hospitals and, to ensure that efficient use is made of the services available, there must be an increased screening of patients and a check on the efficiency of treatment given at the out-patient department.

The size of the area served by these centralized hospitals is such that the patient often has to travel a considerable distance to reach the hospital. There is necessarily a tendency for the out-patient departments to extend and split off, and form separate and distributed diagnostic centres offering consultant and minor therapeutic services to the community. When these functions are combined with the preventive medical services conducted in the ante- and post-natal and child welfare clinics, and in the houses of the community by health visitors and district nurses, we have the polyclinic.

The polyclinic is the centre of prophylactic medicine for the community. Its services relieve and filter the patient load on the parent hospital, by early diagnosis and cure of the sick, the care of the convalescent, education in hygiene and generally watching over the health of the community.

In order to investigate the need for a polyclinic in the community and the extent to which it would relieve the load on the parent hospital, an experimental polyclinic was designed in the new Bantu urban area of Meadowlands, Johannesburg.

To determine the extent of the accommodation required it was necessary to know how many patients from a given community size, and what percentage of these, could be expected in each clinic. Studies were therefore made at 6 urban polyclinics for Bantu in the Transvaal. In Table I the number of patient visits at each of these polyclinics

per year is divided by the population, to arrive at an average number of visits per person per year. This proved to be 3.9 and provides a basis for estimating the number of patients that can be expected at a polyclinic; i.e. if A = the total

TABLE II. PATIENT ATTENDANCES AT CLINICS IN SIX POLYCLINICS

Curative clinics	Ante-natal clinic	Child welfare clinic	Tuberculosis clinic
82%	5%	13%	
42%	8%	50%	
63%	10%	15%	7%
72%	7%	9%	11%
80%	5%	15%	15%
73%	4%	25%	6%
Average 68%	6.5%	21%	9.5%

attendances per year, f the average number of visits per person per year and P the total population, then $A = fP$. Table II shows the average distribution of the patients amongst the main clinics in the same 6 polyclinics. This provided the basis for estimating the attendances at Meadowlands polyclinic, and hence the accommodation necessary.

At the opening of the polyclinic, the population of Meadowlands was approximately 30,700. During the first 13 weeks of operation this figure rose to 32,300. Therefore, to assess the accuracy of the method of predicting the size of the polyclinic, it is necessary to compare the predicted attendance figures with the actual attendance figures given in Table III for each of the 13 weeks. It will be seen that the actual attendance figures are considerably lower than the

TABLE III. PREDICTED AND ACTUAL WEEKLY ATTENDANCES AT MEADOWLANDS POLYCLINIC

Predicted attendances (approx.)	Actual attendances	68% of predicted attendances (approx.)	Actual attendances (curative only)†
2,300	719	1,560	643
2,300	1,426	1,560	1,321
2,300	1,642	1,560	1,584
* 2,350	1,546	1,580	1,485
* 2,350	1,436	1,580	1,436
* 2,350	1,564	1,580	1,515
* 2,400	2,071	1,600	2,018
* 2,400	1,957	1,600	1,873
* 2,400	1,806	1,600	1,717
* 2,400	1,915	1,600	1,835
* 2,450	1,992	1,660	1,917
2,450	1,781	1,660	1,678
2,450	1,645	1,660	1,534

* Excluding patient visits to tuberculosis and venereal disease clinics, which were omitted as the figures were not available at all polyclinics.

† First 8 weeks of full operation.
‡ Exclusive of anti-natal cases.

TABLE I. SIX URBAN BANTU POLYCLINICS

Population	Patient visits per year*	Average visits per person per year
10,479	38,008	3.7
14,490	46,551	3.2
40,000	115,332	2.9
70,000	265,776	3.8
5,300	31,757	6.0
23,891	98,252	4.1
Average		3.9

predicted attendance figures. This is because the polyclinic is run by the Provincial medical services, which are mainly concerned with a curative service; that is to say, all those attending are treated as sick patients, which excludes purely preventive clinics. From Table II it will be seen that patients attending curative clinics constitute 68% of the total attendances. A comparison on this basis, of predicted attendances with actual attendances (Table III) shows that within the nature of the service the pattern of patient attendances at Meadowlands polyclinic conforms to the patterns observed in urban polyclinics in the Transvaal.

To determine further the effect on the medical services, patient attendances at the casualty and out-patient departments of Baragwanath Hospital—the parent hospital to the Meadowlands polyclinic—were studied before and after the opening of the polyclinic. In Fig. 1 these are compared with the increase in population at Meadowlands. It will be seen that after the polyclinic opened, attendances of Meadowlands patients dropped from 3.56 to 2.46 patients per 1,000 population per week at Baragwanath Hospital.

In Table IV, patient attendances at the polyclinic are analysed in relation to those at Baragwanath hospital. It will be seen that the patient attendances at Baragwanath hospital are higher than the number of patients referred by the polyclinic. The reason for this is that some Meadowlands patients go direct to the casualty and out-patient department at Baragwanath Hospital without first attending the polyclinic, either because the polyclinic is closed or for personal reasons.

TABLE IV

Weekly attendances at Meadowlands Polyclinic	Number referred to Baragwanath Hospital	Weekly attendances of Meadowlands patients at Baragwanath Hospital		
		Casualty and OPD	Paediatric OPD	Total
719	1	83	25	108
1,426	4	68	10	78
1,642	1	53	9	62
*1,546	31	72	23	95
*1,436	32	72	17	89
*1,564	31	56	30	86
*2,071	32	55	19	74
*1,957	24	61	24	85
*1,806	25	63	26	89
*1,915	42	50	18	68
*1,992	38	55	19	74
1,781	26	61	12	73

* First 8 weeks of polyclinic in full operation.

An analysis of the attendances at Baragwanath Hospital (as in Table V) shows that if an embargo were placed on patients' going direct to the parent hospital (except on Sundays when the polyclinic is closed) the patient attendances at the casualty and out-patient departments would be further reduced to approximately 0.7 patients per 1,000 population per week. The figures in the last column of Table V indicate that such a reduction is taking place.

It will be seen from Tables III and IV that in the first eight weeks of full operation 14,287 patients attended the polyclinic of which 255 (or 1.8%) were referred to the hospital. So if we term the number of patients referred to the parent hospital from the polyclinic R then the demand for specialist diagnostic and treatment facilities for any given Bantu urban community can be assessed from the

TABLE V.

Total attendances at Baragwanath-casualty and OP patient departments	Patients referred from polyclinic	Patients going direct to Baragwanath	Patients at Baragwanath on Sunday	Patients going direct during the week
108	1	107	17	90
78	4	74	13	61
62	1	61	10	51
*95	31	64	6	58
*89	32	57	12	45
*86	31	55	17	38
*74	32	42	12	30
*85	24	42	15	27
*89	25	64	16	48
*68	42	26	6	20
*74	38	36	7	29

* Polyclinic in full operation except for dental clinic.

ratio $R \div A$ (where A is the total attendances at the polyclinic per year).

Table VI analyses the attendances at Baragwanath Hospital of patients referred from the polyclinic. It shows that the greatest demand is for X-ray diagnosis and the question will naturally arise whether it is not advisable to install

TABLE VI.

Total referred	X-ray diagnostic	Paediatric OPD	Ante-natal clinic & Gynaecology clinic	Dental clinic	Surgical register	Medical register	Ear, nose and throat	Eye clinic	Physiotherapy	Admissions
1	—	—	—	—	1	—	—	—	—	1
4	—	—	3	—	—	—	—	—	—	2
1	—	—	—	—	—	—	—	—	—	1
• 31	11	1	7	1	3	5	—	1	—	4
• 32	15	4	1	3	3	3	—	1	—	6
• 31	13	4	4	—	3	7	1	—	1	9
• 32	16	2	1	4	3	7	—	—	—	4
• 24	15	7	2	—	1	3	2	—	—	3
• 25	17	14	1	—	3	3	—	—	1	5
• 42	30	21	1	—	7	4	—	—	—	3
• 38	19	15	3	1	3	7	—	—	—	4
† 255	136	68	20	9	24	35	3	2	2	38
‡ 1.8	0.95	0.48	0.41	0.063	0.16	0.25	0.021	0.014	0.014	0.27
%	%	%	%	%	%	%	%	%	%	%

* First 8 weeks of full operation except for dental clinic (preceding 3 weeks not included in totals).

† Totals. ‡ Percentage of total attendances at polyclinic.

equipment in the polyclinic to obviate the expense of sending patients to the parent hospital. The answer to this can only be determined by investigation, but as the average number referred for X-ray diagnosis is at present less than 3 patients per day, it would appear unnecessary to decentralize these facilities.

Another point that arises out of Table VI is that in correlating the number of patients admitted to hospital after being referred from the polyclinic, the population of the area and the average stay in a hospital, it is possible to predict the number of hospital beds necessary for a given area. For instance if we take B as the number of beds required, a as the number of patients admitted to the in-patient department for treatment after being referred from the polyclinic, S as the average patient stay in days, and P as the population in thousands, then

$$B = \frac{aS}{365}, \text{ and } B = \frac{aS}{365} \times \frac{1}{P}$$

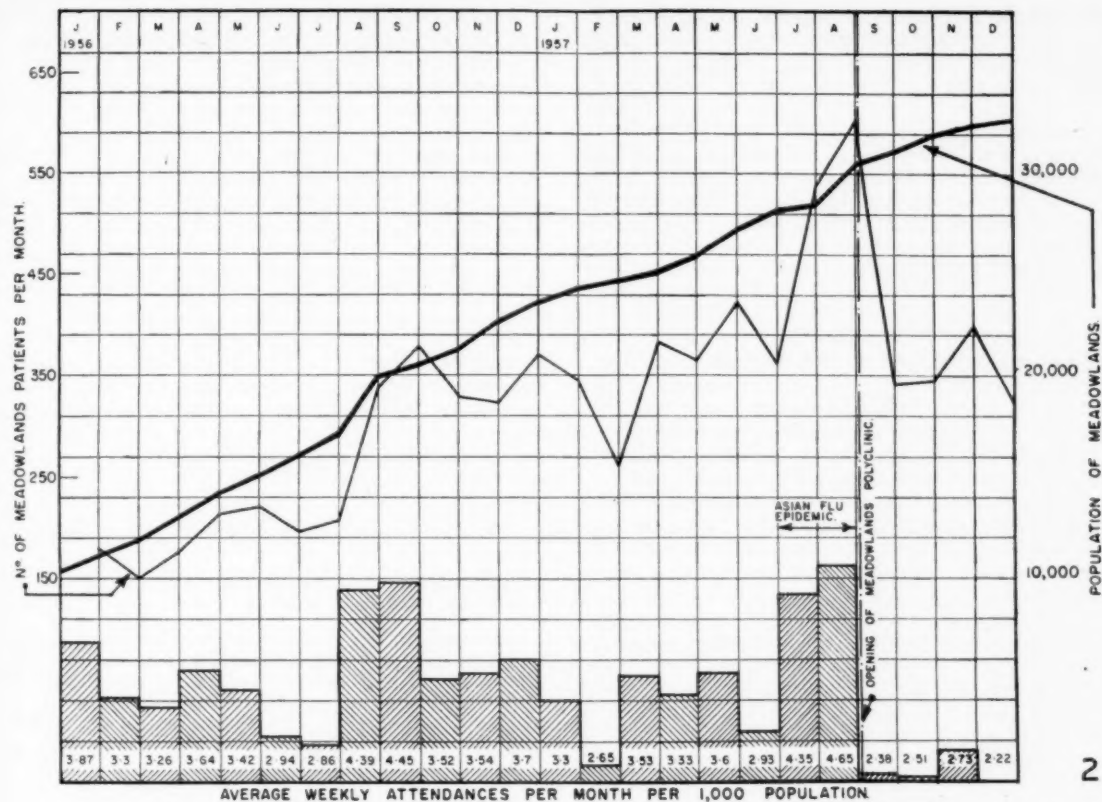


Fig. 1. Comparison of attendances of patients from Meadowslands at Baragwanath Hospital.

will express the community's requirements in beds per 1,000 population. On the figures available for the Meadowslands polyclinic, together with an average stay of 10 days in hospitals in that area, the demand appears to be 0.2 beds per 1,000 population.

Table VII shows the total admissions at the two general hospitals (Baragwanath and Coronation) serving the area in which Meadowslands is situated, compared with the admission figures for patients referred from the polyclinic for specialist attention to Baragwanath Hospital. When

TABLE VII.

Admissions from Meadowslands at:		October	November	December
Baragwanath Hospital ..	..	74	54	76
Coronation Hospital ..	..	13	7	6
Total* ..	..	87	61	82
Admissions at Baragwanath Hospital of patients referred from Meadowslands ..		23	25	24

* These figures indicate that the actual demand is 0.7 beds per 1,000 population.

considering these figures it must be remembered that the polyclinic reduces the number of patients admitted to hospital by diagnostic filtering and treatment in the polyclinic and at home. The latter, in the form of follow-up care, can

further relieve the bed demand by making possible earlier discharge and consequently reducing the average stay.

An analysis, by medical opinion, of the cases admitted directly to Baragwanath Hospital (i.e. those who have not attended the polyclinic first) indicates that as the hospital

TABLE VIII. COSTS PER PATIENT UNIT IN SHILLINGS

Direct Costs	Baragwanath Hospital			Meadowlands Polyclinic
	In-patients	Casualty	Out-patients	
Provisions ..	..	..	..	..18
Surg. and pharm. supply ..	6.53	2.16	1.99	1.55
Domestic ..	.93	.07	.04	.25
Buildings and grounds ..	.32	.02	—	—
Salaries, wages and allowances ..	6.36	1.76	2.62	2.35
Sub-total ..	14.14	4.00	4.65	4.33
Indirect Costs				
Tea-room feeding ..	.6	.02	.02	—
Main kitchen ..	2.4	.46	.04	—
Compound ..	.11	—	—	.04
Doctors' quarters ..	.15	.06	.06	—
Nursing service ..	5.22	.61	.24	—
Theatre ..	.80	—	—	—
Physiotherapy ..	.17	—	.03	—
X-ray ..	.75	3.27	1.02	.13
Occup. therapy ..	.24	—	.04	—
Orthopaedic workshops ..	.20	—	.84	—
Boiler house ..	.27	.10	.09	—
Linen and sewing room ..	.29	.11	.10	—
Workshops ..	1.09	.42	.38	.29
Administration ..	5.26	2.01	1.85	1.44
Hist. laboratory ..	.24	.09	.09	—
Grand total ..	31.43	11.15	9.72	6.23
Attendances (patient days) ..	48,138	14,304	12,092	7,660

authorities become more accustomed to the polyclinic service, and the latter perfects itself, the community's demand for beds will be reduced. Further investigation will be carried out to determine the extent of this reduction.

Finally, the costs of treating patients at the polyclinic and in the hospital are compared in Table VIII. From this it will be seen that the unit cost of treating a patient at the polyclinic was 56% and 64% respectively of that of treating him in the casualty and out-patient departments, and 20% of that of treating him as an in-patient. Further the cost of the polyclinic services per head of population per year can be estimated by taking

$$\frac{\text{the unit cost} \times \text{number of attendances}}{\text{total population.}}$$

At Meadowlands this works out at 24s. per year.

SUMMARY

The effect of a polyclinic in a lower income group depends on the demand of patients for its services, expressed in terms of patient attendances per year, determined from $A=fP$ (where A is the total attendance, f the average attendance per person, and P the population). In urban areas in the Transvaal this demand can be assessed by multiplying the population by a factor 4 to estimate the total patient attendances per year where full services (i.e. curative and preventive) are given, and by a factor of $4 \times 68 \div 100$ where partial services (i.e. curative and ante-natal clinics and excluding tuberculosis cases) are given.

A comparison of patient attendances from Meadowlands at the Baragwanath casualty and out-patients departments before and after the opening of Meadowlands polyclinic

shows that there was a drop from 3.56 to 2.46 patients per 1,000 population per week at Baragwanath Hospital.

The need for the comprehensive specialized services of the general hospital by patients attending the polyclinic can be assessed as being approximately 1½% to 2% of the attendance figures at the polyclinic. In this number 0.95% required the diagnostic services of the X-ray department and 0.27% were admitted as in-patients.

The number of hospital beds that a community requires, assuming full occupancy, is given by the formula $B=aS \div 365$ where B is the number of beds, a the number of patients admitted to hospital, and S the average patient stay in days at the hospital. In Meadowlands where there are full polyclinic services this proved to be 0.7 beds per 1,000 population.

The costs of treating a patient in the polyclinic were as follows: 64% of the costs when treated in the out-patient department; 56% of the costs when treated in the casualty department; 20% of the costs when treated as an in-patient. It is also possible to assess the costs per head of population per year by the formula

$$\frac{\text{unit cost per patient} \times \text{patient attendances at polyclinic}}{\text{population.}}$$

At Meadowlands this was found to be 24s. per head of population.

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AVULSION OF THE DISTAL TENDON OF BICEPS BRACHII FROM THE RADIAL TUBEROSITY

W. J. J. THOMAS, M.Ch. (CAPE TOWN), *Chamber of Mines Hospital, Johannesburg*

Closed rupture of the biceps muscle or its tendons following indirect violence is a comparatively rare injury and when it occurs the rupture is more likely to affect the long head of origin than the distal tendon. While ruptures of the long head have received adequate attention in surgical text-books, the same cannot be said for avulsion of the distal tendon and the surgeon encountering this lesion for the first time may not be fully prepared to deal with the pathology disclosed at operation.

Storhsin first identified the lesion at autopsy in 1842.⁹ Credit for the first clinical description has been given by most writers^{6,27} to Aquaviva¹ (1898), but Lee¹⁸ has pointed out that in 1897 Johnson¹⁴ reported on a case in the *New York Medical Journal*.

Frequency

Views of different writers vary not only in regard to the frequency of bicipital ruptures in general but also as to the relative incidence of ruptures of the long tendon as compared with distal avulsions.

Platt²² stated, 'Rupture of the long head of the biceps is by no means an uncommon injury'; but his personal series of operations for complete tendon ruptures included

no example of rupture of the long head of biceps. He could find no record in the literature of rupture of the distal tendon, but had operated on a case of avulsion of this tendon from the radial tuberosity. Watson-Jones²⁸ lists various predisposing factors which explain the 'frequency' of rupture of the long proximal tendon of biceps, but stated that less than 40 cases of rupture or avulsion of the distal tendon had been recorded.

Mercer²¹ agrees that 'rupture of the biceps insertion at the elbow is exceedingly rare' and quotes the case reported by Platt. However, Harris¹³ and Keen¹⁵ could trace only about 100 recorded cases of rupture of the long head in the literature up to 1935.

Gilcreest¹⁰ in a comprehensive review of the whole subject of bicipital ruptures in 1934 analysed 100 reported cases, of which 73 had been subjected to operation. The comparative rarity of this type of injury was indicated by the fact that only 15 cases could be collected from the Mayo Clinic over a 15-year-period. In the series reviewed by him, Gilcreest found the long head involved in 57 cases, the muscle belly or musculo-tendinous junction in 40, and the distal insertion in only 3. He compared these figures with those of Petit (which were respectively 52, 28 and 3) and

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Biancheri (96% long head, 3% distal tendon). At that time there were apparently only 19 cases of rupture of the lower tendon previously recorded in the literature.

Between 1937 and 1939 Dobbie⁴ encountered 2 cases of disinsertion of the distal biceps tendon and was able to trace only 24 cases reported in the literature. He circulated 490 members of various surgical and orthopaedic associations in America and was able by this means to collect 51 further cases not previously reported. Lee¹⁸ in 1951 brought the total of recorded cases up to 98.

In this paper I draw attention to a further 18 cases reported by various authors,^{3-5,7,8,12,16,27} and give details of 2 additional cases seen at the Chamber of Mines Hospital, Johannesburg, during the past year.

Since this hospital was opened in 1939 for the treatment of injured miners, 32,752 patients have been admitted, and our records show the following figures for major or complete ruptures of muscles and tendons of the shoulder and upper limb:

Supraspinatus	..	..	..	..	..	6
Biceps: Long head	..	..	..	..	4	} 8
Muscle belly (direct violence)	..	..	..	..	2	
Distal tendon (avulsion)	..	..	..	..	2	
Triceps (partial avulsion, central slip, distal tendon)	..	..	..	..	1	

These figures may be compared with those of Stimson, quoted by Christie,³ who found 3 cases of rupture of the biceps out of 10,000 injured patients examined, and Waugh,²⁷ who encountered 50 cases (45 involving the long head and 5 the distal insertion) out of 60,792 admissions.

It is of interest to note that Waugh places the biceps first in order of frequency of muscle and tendon ruptures while Gilcreest, who contributes the chapter on the surgery of muscles and ligaments in Christopher's *Text-book of Surgery* gives the order: (1) Calf muscles, (2) extensors of leg, (3) biceps of arm, (4) Achilles tendon, (5) extensors of thumb.

Aetiology and Pathology

Avulsion of the biceps tendon from the radial tuberosity occurs usually in males in the 5th and 6th decades. Though it is rare under the age of 40, there are 2 recorded instances in patients aged 32.^{18,27}

Typically the lesion results from sudden forcible extension of the actively flexed elbow, and the dominant arm is the one commonly affected. Most surgeons who have resorted to operation have commented on the fact that the avulsion is a 'clean' one, leaving a smooth area on the tuberosity without tendinous remnant or elevation of bone flakes. Davis⁵ has suggested the possibility of a hypertrophic anterior edge of the tuberosity leading to frictional changes in the tendon, but this feature has not been previously described, nor was it encountered in the patient operated on here.

Symptoms and Signs

The following are so constant as to be pathognomonic:

1. Immediate pain in the antecubital region, occasionally with the sensation of a 'snap'.
2. Local tenderness and slight swelling in the antecubital region with ecchymosis developing in 2 or 3 days.
3. Deformity of the biceps with the belly retracted proximally.

4. Biceps tendon cannot be palpated while brachialis becomes more easily palpable.

5. Weakness in power of elbow flexion and supination.

Treatment

All writers have advocated operative treatment, but Waugh²⁷ has added, 'Treatment depends upon the degree and site of the rupture, the age of the patient, . . . the kind of work the patient may have to do in the future.'

The operations devised have had as their objective one of two alternatives:

1. Reattachment of the tendon to the radial tuberosity by nail, *via* drill holes or other means.^{2,3,10,17,18,22}

2. Suture of the detached biceps tendon to the soft tissues, particularly the tendon of brachialis.^{6,11,16,27}

Those who favour the second alternative consider that surgical exposure of the radial tuberosity is not without risk of damage to important structures, and is not essential from the point of view of restoring function.

The results following operation have in the main been described as 'good' or 'excellent', irrespective of the type of operation performed. It is worthy of note, however, that even when conservative treatment is adopted, the permanent functional disability in the elbow is not great.

CASE REPORTS

Case 1

Mr. G.E., aged 49, an instructor at the Government Mining Training School, reported at this hospital on 13 November 1956, complaining of pain in the right elbow region. He stated that at 11 a.m. the previous day, while walking down a gully underground, he had slipped and, to save himself falling, had thrown his right arm round a supporting prop, at the same time flexing the elbow forcibly. As he regained his feet he experienced a cramp-like pain in the right biceps muscle, which he found bunched up towards his shoulder. He pushed the muscle down towards his elbow with his left hand and this relieved the cramp, but a short while later he attempted to lift some object and the cramp and deformity of the biceps recurred temporarily. The following morning he noticed an area of 'bruising' on the elbow and saw his panel doctor, who referred him to the Chamber of Mines Hospital.

On examination, the salient features were:

1. Ecchymosis on the medial aspect of the right arm in its lower third, the elbow and the upper two-thirds of the forearm.
2. Tenderness in the antecubital region.
3. Deformity of the biceps, the belly of which was bunched into the proximal half of the arm, especially during strong active contraction.
4. Absence of biceps tendon in antecubital region; brachialis more easily defined.
5. Full flexion and extension of elbow but power of flexion and of supination diminished.

Operation was undertaken on 22 November by Mr. E. B. H. Trehair, F.R.C.S., under general anaesthesia and a bloodless field, when I acted as assistant. Henry's incision was used and once the radial recurrent leash of vessels had been ligatured and cut, a very good exposure of the operative field, including the tuberosity of the radius, was obtained. The distal biceps tendon was found lying quite free on the underlying brachialis muscle, with its extreme tip bulbous and slightly haemorrhagic (Fig. 1). A hiatus was found in the soft tissues where the tendon had 'pulled out' and a director could be passed through this down to the tuberosity of the radius. After a small portion of the supinator muscle had been reflected, and with the forearm in full supination, the tuberosity was well exposed and the bare area about $\frac{1}{2}$ of an inch in diameter from which avulsion had occurred was clearly seen. This was quite smooth, with no suggestion of ridging or flaking. Two drill holes were made transversely through the tuberosity, its surface was roughened slightly and the biceps tendon was sutured into position with braided wire (Fig. 2).

The elbow was immobilized in almost full flexion and supination

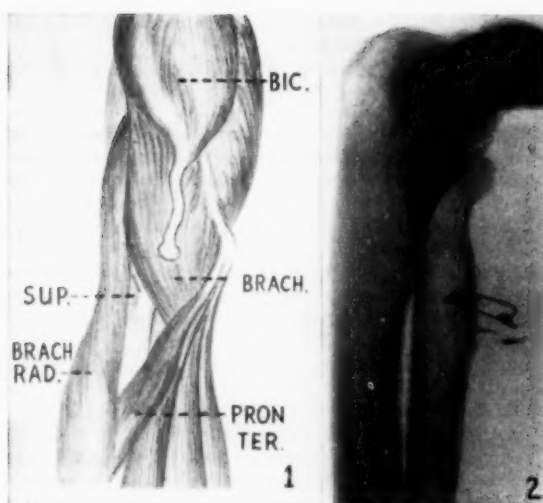


Fig. 1. Case 1. Names of muscles: bic.—biceps, brach.—brachialis, sup.—supinator, brach. rad.—brachioradialis, pron. ter.—pronator teres.

Fig. 2. Case 1.

for 3 weeks and then at a right angle for a further 2 weeks, after which active exercises were instituted.

The patient resumed work 10 weeks after the operation and was finally examined for assessment of permanent disability on 9 May 1957. At that stage the biceps contour was normal and the distal tendon could readily be felt spanning across the antecubital fossa. Flexion was full but extension was limited by 20°; supination was full and powerful, but pronation was limited by 30°. By merely flexing the elbow he could lift 15 lb. on the right and 20 lb. on the left. Permanent disability was assessed at 7½%.

Case 2

Mr. L.H.L., aged 64, a construction worker underground, reported at this hospital on 8 February 1957 about 2½ hours after an injury to his right elbow region. He stated that he was holding up one end of a pipe when the men who were lifting the other end up a vertical shaft suddenly let go, so that he took the whole weight of the pipe on his right forearm, his elbow being held at right-angled flexion. He experienced a sharp pain over the front of the elbow and a feeling of weakness. He was sent direct to the Chamber of Mines Hospital.



Fig. 3. Case 2.

The clinical features, as shown in Fig. 3, were identical with those of the previous patient except that the ecchymosis did not appear until 2 days later and was distributed chiefly over the medial and posterior aspects of the elbow, and the upper third of the forearm. X-ray was negative. In view of the patient's age, a conservative line of treatment was adopted—radiant heat, light massage and gentle active movements at a comparatively early stage.

Two weeks after injury it was noted that extension of the elbow became limited by 25° and the skin was slightly puckered and adherent over the site of the distal biceps tendon. This restriction of movement disappeared after a further 2 weeks and he resumed work 6 weeks after injury.

At the time of final examination on 10 June, the biceps deformity was still present, the distal tendon could not be felt, and the slight 'dimpling' of the skin over the distal tendon was still evident. Flexion and extension, pronation and supination were all full. Supination power was diminished by about one-half. By flexing the elbow he could lift 12½ lb. on the right, 17½ lb. on the left. If the forearm was supinated he used the brachialis chiefly to flex the elbow; in pronation and neutral position the brachioradialis also contracted strongly. Permanent disability was assessed at 5%.

CONCLUSIONS

1. While rupture of the biceps is not a common injury and when it occurs is most likely to affect the long head, avulsion of the distal tendon from the radial tuberosity is not so rare as to be regarded as a surgical curiosity.

2. The syndrome is so characteristic that diagnosis presents no difficulty.

3. If surgical repair of the lesion is contra-indicated by the age of the patient, or for other reason, the functional disability in the elbow is not gross.

4. If operation is undertaken, reattachment of the tendon to the tuberosity of the radius should be carried out; this improves the power of supination. There has been a tendency to place too much stress on the risks involved in surgical exposure of the tuberosity. If Henry's approach is used the operation offers no particular technical difficulties.

I should like to thank the management of the Rand Mutual Assurance Co. for authority to publish these cases, Mr. E. B. Trehair for permission to publish his case, and Mr. I. Macgregor for making the diagrammatic drawing (Fig. 1).

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MY YEAR AS PRESIDENT

H. GRANT-WHYTE, B.A., M.B., CH.B. (CAPE TOWN), F.F.A.R.C.S. (ENG.), D.A. (LOND.)

President, Medical Association of South Africa, 1957-58

Having completed my year as President of the Association, I want to share the regret expressed by one or two of my predecessors at having been unable, during the year, to take advantage of the many invitations I have received to visit various Branches. But the pressure of work following Congress, together with two visits to England, on which I shall comment later, made it quite impossible for me to do what I should like to have done, and what I believe every President should do—keep in the closest touch by way of personal visits with as many of our Branches as possible.

This said, it seems a contradiction to remark that as President, my office has been something of a sinecure, a contradiction borne upon me by the amount of work done by the Association's permanent officials, and by the executive of the Federal Council. The Chairman's report, a copy of which has already appeared in the *Journal*, provides members with a resumé of the year's activities, details of which I need not repeat here.

The highlight of any presidential year is our medical congress, this time held in Durban, and crowned, I think, with great success. We had with us a galaxy of overseas visitors, whose presence at congress gave new inspiration to our Association and also brought to the general public a lively appreciation of the role our profession plays in human society.

There is no doubt that such visits raise the status of the profession in the eyes of the public, encourage that sense of unity which is finding expression in the World Medical Association, quite apart from the valuable knowledge we gained from their specialized contribution to our deliberations.

Last year I attended the annual congress of the British Medical Association at Newcastle, as President elect of our Association, and then again this year at Birmingham. On both occasions I had the opportunity of listening to some of the discussions of the Representative Body, which assembled a few days previous to the opening of congress, and which, as you know, is to the British Medical Association what our Federal Council is to our Association—the formulator of policy.

Those of you who have followed the reports of this Body will be aware of the deep sense of unease and frustration, amounting in some cases to rebellious discontent, among British medical men, with the conditions of service within the National Health Scheme. I doubt whether at any time in the history of the BMA has so much space been devoted in the reputable newspapers and professional journals to any aspect of the medical profession. In fact, emerging from the conflict with the present government on conditions of service, and as an inevitable result of nationalization of health, the profession has entered the realm of politics—medical politics.

The British National Health Service

A nationalized service of any kind envisages negotiated conditions of work with the employer-government, and it is not to be supposed that, drawn into a National Health Scheme, the medical profession can escape the problems which previously we have associated primarily with the many variations of trade unionism.

A Royal Commission is now enquiring into the subject, but perhaps I can best reflect the whole situation, as I saw it, by quoting the following authors: Dr. S. Wand, chairman of the Council of the BMA, writes: 'After ten years of National Health Service, the public has had wonderful value for its money. There are doctors who feel themselves above medical politics. They are walking about with their heads in the clouds, because in the National Health Service political action is necessary to preserve those essential professional freedoms which doctors must have in carrying out their work.'

Dr. B. Burns, from Sheffield, writes: 'The frustration of family doctors in the National Health Service arises from two basic causes: (1) the terms of service are inseparable from capitation fee remuneration, and (2) the abuse of the free service by certain patients. The capitation method of payment is the nearest approach to medical serfdom any country has yet achieved. The capitation fee brings out the worst in the doctor, and the free service brings out the worst in the patient.'

Dr. J. S. Noble, Member of the Council of the BMA, writes: 'While many doctors were not contented with all aspects of the National Health Service, to imply that all doctors were unhappy, frustrated and trammelled by an unpleasant minority, was unjustified. Doctors are responsible for the running of their practices. Patients respond to the treatment they get. Slack doctors produce contempt; efficient doctors produce respect.'

Some Activities of the BMA.

I was interested in two features of the BMA's activities which, I feel, we might well take over in South Africa. The first is the establishment of what has been called the Junior Members' Forum, which promises to be a permanent institution providing a platform for younger doctors for the discussion of their problems, and encouraging them to take their rightful place in the organization. The initial meetings of this Forum proved very successful, and it is generally felt that it has a good contribution to make. I should like to see something similar here in the Union, and I hope that Federal Council will give the subject some attention.

In addition to this, though at the other end of the scale regarding age and experience, there is the practice of the BMA to honour those who have served it well and faithfully by conferring on them the title of Fellow and adding their names to a Roll of Fellows.

In our own Association the practice is to confer a title of honour only after 40 years of membership. I think it would lend grace and distinction to the Association if we introduced something on the model of the BMA whereby the worthiest of our members might be invested as Fellows and a roll of their names preserved in an appropriate place.

One abiding impression I have of my visits overseas is the sense of unity permeating the profession. There is a strong desire in British medical circles to avoid the dangers inherent in the kind of political solidarity that meets the needs of other professional bodies, to avoid, in fact, anything in the nature of trade unionism. It is generally felt that 'medicine', of all nationalized services, should lie outside the field of political action, and that the profession's salvation is to be found in partnership with the government and public, soundly based on justice and service.

Financial Considerations

To return to our own affairs, a subject that is causing some disquiet is our depleted exchequer. We are not alone in this. It is a fact, however, that our finances will continue to require close attention for reasons that will no doubt be set out by the appropriate committee. Many of their reasons have been detailed in the report of the Hon. Treasurer, Mr. J. D. Joubert.

In comparison with other countries, there is a good case for an increase in the subscription fee, and an even better case for it in terms of actual value received. It is heartening too, to find so many members responding so generously to the appeal for donations, though it is generally recognized that, whereas donations may tide us over a difficult period, they do not provide a permanent solution to the problem.

It is true, of course, that city and town members obtain more value for their money than do country members. This also applies to the doctor in private practice in comparison with the doctors in university teaching positions or in permanent hospital appointments. I have long hoped that the Association might do more to advance the interests of both these groups. The country doctor is at a disadvantage in his inability to attend meetings; the institution doctor is at a disadvantage in the feeling that so many of the matters that concern the Association do not affect him. He often feels that he is left out and that the Association does not take sufficient interest in his problems.

One aspect of the financial problem is the economics of our publications, especially of the *Journal*. Related to this problem is the appearance of other publications of a medical character with which the *Journal* is in competition for advertising revenue. If report is true, we have to face the prospect of still further publications within the same field.

The financial success of the *Journal* depends solely upon revenue from advertising, and that is more difficult to maintain than editorial excellence. Any adverse change in the relation between advertisements and text can quickly put any publication in the red. While the number of text pages in the *Journal* increases, the number of advertisements remain more or less static and the problem thus hinges on how to increase advertising.

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The publication of the Collins report aggravated that feeling of uneasiness. It was recognized that many of the criticisms in the report were factually correct, and that there was a real danger of general practitioners becoming academically isolated, and of many of the standards and traditions of good general practice being lost.

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Committee, and on matters of terms and conditions of service a highly skilled and efficient organization had been built up by the British Medical Association. But, in so far as *scientific and academic matters* were concerned, the general practitioner had for many decades just muddled or drifted along. Those who were keen clinicians and had taken higher qualifications frequently obtained hospital posts but, with the coming of the National Health Service and the vast increase in the number of hospital posts of the Registrar and S.H.M.O. grade, the general practitioners were edged out, left out and, in many cases, after years of service to a hospital, pushed out. From the academic standpoint they were completely unorganized and they had no one of standing of the Royal Colleges to put forward their claims or their aspirations. Gradually, an ideal was formulating that a College of General Practice would inspire practitioners to regain their rightful place in the medical hierarchy.

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These memoranda occasioned widespread interest, and numerous doctors wrote in, commending the project by a majority of 50-1. Encouraged by this, a *Steering Committee* was convened under the Chairmanship of Sir Henry Willitt, a former Minister of Health. At this Committee were 5 general practitioners (increased to 10) and 5 consultants of eminence, and in December 1952 their report and recommendation were published in the *British Medical Journal* of 20 December. On 18 February 1953, the *Foundation Council* was created by the addition of 11 members to the 10 members of the Steering Committee. The Foundation Council was selected partly on a geographical basis because it was felt that this new College must be of country-wide appeal and that to concentrate its sponsors chiefly from London would be fatal to success.

The conclusions of the Report of the Steering Committee may be of interest to you who contemplate the establishment of a College in South Africa: 'General practice is the oldest branch of medicine; over 80% of this country's illness is cared for by family doctors and here, as in our great Dominions and the United States of America, it has been found that one of the most difficult tasks in medical administration and planning has been to find the proper role of the general practitioner in modern medicine. There is taking place now a world-wide reorientation of ideas about his capabilities and responsibilities, with a steadily growing conviction that general practice is fundamentally as important as the specialities and that it cannot be controlled by specialist organizations. General practitioners have been in the past, and must be in the future, good doctors practising medicine in their own right; they are essential to the heart and soul of medicine. It is being increasingly realized that this development and emancipation of general practice is not only a question of professional pride and status, but is an urgent economic need—to keep patients out of hospitals whenever they can be investigated and treated at home. (In passing, a hospital bed now costs anything from £18 to £30 per week.) Only by developing a higher standard of general practice, with full access to hospital and laboratory facilities, can the present overcrowding of out-patient departments and increasing specialist consultations be avoided.

'A golden opportunity now presents itself for general practitioners to found an organization of their own to watch over their academic interests, their privileges and their education. No existing body is doing now, or will be able to do in the future, what is required. The formation of a new College to lead general practitioners and to uphold their rightful place in the National Health Service will help them more than any existing organization can do, and the influence of such a college for the good of general practice cannot fail to be profound. There is an immediate need for general practitioners to establish for themselves an academic body.'

With these high ideals to inspire them, the Foundation Council got to work. Committees were appointed, viz. (1) Finance and General Purposes, (2) Postgraduate Education, (3) Undergraduate Education, and (4) Research.

To ensure the successful inauguration of a new Council of the College requires a secretary of vision and of driving force. The success of our College has been due in very large measure to the initiative, ability, charm and vision of John Hunt. He was responsible for the formation of the Steering Committee, for the selection of the right individuals, and for enlisting the support of the leaders of medical opinion in all sections of the profession; and above all for the efficient organization of the secretarial work. This has imposed a tremendous burden on his time and energy, but he has always proved more than equal to the demands made upon him. It has been said that, in times of stress and difficulty, a leader always arises, and we in our College can truly say that the unselfish leadership of John Hunt has been the major factor in our successful progress.

In 1845, an attempt was made to found a College of General Practitioners, and at a meeting of 1,200 practitioners it was decided to found a 'National Association of General Practitioners in Medicine, Surgery and Midwifery'. The feeling of the meeting was ardent, enthusiastic and unanimous, but many irresponsible and indeed unforgivable blunders were made. Of its first Council

of 60 members, only one resided outside London, and this aroused much indignation, especially amongst country practitioners, and a good deal of arrogance from the Colleges of Physicians and Surgeons, who felt that the new Association might weaken their authority. A vast amount of argument ensued in the medical journals of the day and it was finally agreed that the College of Practitioners might be founded as an equal College with the two existing Colleges. But the virtual exclusion of country practitioners from their Council caused the proposed College to lose its nation-wide attraction and, in 1846, the project was dropped and the College of Surgeons opened their doors to those general practitioners who were at that time interested in surgery, and general practitioners as a class again sank deep into the slough of despair.

Our young College received an enthusiastic welcome from almost every body associated with medical education and even with medico-political affairs, and from many overseas societies and associations. The young College was determined not to make the mistakes of 100 years ago and the first Foundation Council—admittedly self-selected—was elected on a geographical basis. Some of the members had considerable experience of British Medical Association activities, and were able to help in determining constitutional difficulties, but the great majority were men to whom the College was their initiation into administrative work, and they approached our problems with an entirely open mind, with no preconceived ideas about constitution. Invaluable help was given by the Company of Apothecaries, who gave us their Court Room for Council and Committee meetings. Two guiding principles were: (1) not to interfere with the work of other medical organizations, and (2) to avoid medical politics and to restrict College activities to the academic aspects of general practice.

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With regard to the Royal Colleges, it was, from the beginning, made clear that a College of General Practitioners would in no way interfere with the activities of the Royal Colleges. It will perhaps run parallel with them but it will not compete with them. We are all striving for the same goal—to give to the British people the best medical service that can be provided—a renaissance of general practice with its own headquarters directing it cannot but benefit every branch of the medical profession in the country. There should be no conflict between specialists and practitioners. Each group has its particular tasks; each is of equal value to the community; neither can replace the other; both are essential and both are complementary, the one to the other. For the first year or two of our existence, the Royal Colleges tended perhaps to keep aloof—they were not sure whether the infant was viable—but then they recognized our new College as one which was establishing itself firmly in the medical hierarchy and they have been generous in the recognition of the growing child and have shown to us every help and every courtesy. In particular the College of Surgeons has been most generous in offering us a site adjoining their building in Lincoln's Inn Fields as a home for the College which is to be provided for us by a generous donor who still remains anonymous, but who has the future of the College very much at heart. He is providing the building, which we hope will be completed in 1962-63, but we of the College must maintain it. For that we shall be launching an appeal in the near future, and I feel sure that that appeal will receive sympathetic consideration from industry, from charitable foundations, and from men who wish to see the troops well equipped who are in the spear-head of the battle against disease. Already we have received many donations and encouragement, and we face the future full of confidence.

ORGANIZATION

The regional organization of the College is of the greatest importance. The Council felt that members must realize that this is no London-controlled organization but that those in the regions can play their full part and have a considerable amount of autonomy. Headquarters can help all its members and associates

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Our young College received an enthusiastic welcome from almost every body associated with medical education and even with medico-political affairs, and from many overseas societies and associations. The young College was determined not to make the mistakes of 100 years ago and the first Foundation Council—admittedly self-selected—was elected on a geographical basis. Some of the members had considerable experience of British Medical Association activities, and were able to help in determining constitutional difficulties, but the great majority were men to whom the College was their initiation into administrative work, and they approached our problems with an entirely open mind, with no preconceived ideas about constitution. Invaluable help was given by the Company of Apothecaries, who gave us their Court Room for Council and Committee meetings. Two guiding principles were: (1) not to interfere with the work of other medical organizations, and (2) to avoid medical politics and to restrict College activities to the academic aspects of general practice.

A Liaison Committee of 4 Colleges and 4 G.M.S. members was instituted to discuss ways in which the two bodies—the British Medical Association and the College—could be of mutual assistance or help to general practitioners, and to exchange views on any problems which are common to both. It was felt that the work and activities of the College should be complementary to, and not in competition with, the work already being undertaken by the British Medical Association.

With regard to the Royal Colleges, it was, from the beginning, made clear that a College of General Practitioners would in no way interfere with the activities of the Royal Colleges. It will perhaps run parallel with them but it will not compete with them. We are all striving for the same goal—to give to the British people the best medical service that can be provided—a renaissance of general practice with its own headquarters directing it cannot but benefit every branch of the medical profession in the country. There should be no conflict between specialists and practitioners. Each group has its particular tasks; each is of equal value to the community; neither can replace the other; both are essential and both are complementary, the one to the other. For the first year or two of our existence, the Royal Colleges tended perhaps to keep aloof—they were not sure whether the infant was viable—but then they recognized our new College as one which was establishing itself firmly in the medical hierarchy and they have been generous in the recognition of the growing child and have shown to us every help and every courtesy. In particular the College of Surgeons has been most generous in offering us a site adjoining their building in Lincoln's Inn Fields as a home for the College which is to be provided for us by a generous donor who still remains anonymous, but who has the future of the College very much at heart. He is providing the building, which we hope will be completed in 1962-63, but we of the College must maintain it. For that we shall be launching an appeal in the near future, and I feel sure that that appeal will receive sympathetic consideration from Industry, from charitable foundations, and from men who wish to see the troops well equipped who are in the spear-head of the battle against disease. Already we have received many donations and encouragement, and we face the future full of confidence.

ORGANIZATION

The regional organization of the College is of the greatest importance. The Council felt that members must realize that this is no London-controlled organization but that those in the regions can play their full part and have a considerable amount of autonomy. Headquarters can help all its members and associates

wherever they live or work, and the Faculties in return can help Headquarters by supplying information about their needs and aspirations. For educational purposes and to facilitate arrangements for postgraduate study and undergraduate education, the Faculty headquarters have, as far as possible, been situated in apposition to a University centre, although in some instances this has not been possible.

To form a Faculty, at least 10 members are necessary, and in the case of overseas Faculties it was agreed that a quarter of the membership fee would be returned in the first year and a quarter in the second year, and that the remaining 50% would be invested by the Council and would belong to the mother College. Each Faculty will appoint Committees dealing with undergraduate education, postgraduate education, and research, and the Faculties will elect a Provost—an honorary position—Chairman, Deputy Chairman, and Secretary-Treasurer, and from 7 to 18 members according to the size of the Faculty.

The Foundation Council was much concerned with what should be the criteria for membership. The initial criteria were (1) doctors who have been 20 years in general practice or (2) 5 years in general practice and who give an undertaking to accept postgraduate instruction for 5½ days every 2 years, or (3) 5 years in practice and who possess a postgraduate degree or diploma. Since the foundation of the College, a great deal of discussion has taken place about criteria and, at the request of the Annual Meeting, an Examination Committee and a Criteria Committee have been formed, both of which have done most valuable work. Opinions on the necessity for an examination as a means of entry are still very divided, but each year there is a greater swing towards examinations; the most recent questionnaire shows 17 Faculties in favour, and 3 against, with 3 still undecided and unable to make up their minds.

It is rather significant that the demand for examinations comes primarily from the younger members who feel they want some type of diploma which would be of value to them when they apply for practices. Under our National Health Service, practices are awarded by Local Executive Councils who act as fairly as they can, but who have little knowledge or information concerning the academic standards of the applicants. The younger men feel that membership of the College by examination will at least ensure that they are well qualified to deal with the problems that arise in general practice, with which their University education gives them little opportunity of becoming familiar.

The initial criteria have been considerably tightened and to qualify for membership a candidate must now be sponsored by two College members and must submit a full statement of his appointments since graduation. These are considered by a Board of Censors who, if they are not fully satisfied that he will be a satisfactory member, may summon him for an interview, which now takes the form almost of an oral examination. It must, however, be admitted that very few candidates have been rejected but, as membership of the College at present gives, in Britain, no financial reward, it is fair to say that only keen and enthusiastic practitioners seek to join the College. We do not contend that our members are any better doctors than those who are outwith our ranks, but we do say that by joining the College you will meet those men and women who are anxious to maintain and increase their knowledge of modern advances in diagnosis and treatment and are willing to undertake a definite number of hours of postgraduate study. When one mixes with enthusiasts one becomes enthusiastic too, and enthusiasm for his job is the first prerequisite for a good College member. Our membership is now 4,804, including 1,357 associates.

Should you decide to form Faculties in South Africa you would then also form your own Council, which would to a very large extent be autonomous. You would have your own committees and, even if we prescribed an examination for our new members in Britain, that would not, at all events for some years, be enforceable on our overseas members. You would have your own Board of Censors, who would elect members in accordance with the bye-laws and constitution of the parent College and would then submit these names for formal approval.

I would suggest to you that membership of the College in Australia and New Zealand and Canada does confer very definite higher status, and consequently some financial reward to members, because the general public are well aware that membership entails a definite amount of postgraduate work and consequently ensures that the College members are *au fait* with all that is new in medicine.

In Canada, when remitting the annual subscription, the member must also forward a signed certificate stating that he has done 50 hours of postgraduate work each year. If that is not forthcoming, his membership lapses. I am told that, frequently, local authorities are asked by the town inhabitants for lists of College members, and a certificate of membership is granted which they may display along with their other qualifications. Similar benefits accrue to members of the Academy in the United States of America.

Since our early years, progress has been almost incredibly good. Our first President was Dr. W. A. Pickles, a practitioner from the Yorkshire dales who had attained world fame by his work in epidemiology in general country practice. He was a man of charm, integrity and outstanding ability, and he made for us a wonderful ambassador.

PRESENT SET-UP

The College Council now numbers 44 members, 32 of whom are Faculty representatives and 12 are elected at the Annual General Meeting.

We now have our new home in 41 Cadogan Gardens, London, through the generosity of the generous donor, and negotiations with the College of Surgeons are progressing smoothly for our new home in Lincoln's Inn Fields with their most friendly help and cooperation. The new building may well be the mortar which will eventually lead to an Academy of Medicine in Britain (Sir Ernest Finch).

We have Pfizer lectures, Upjohn scholarships, Butterworth medal, Burgess prizes, James McKenzie lectures. The Research Newsletter and Journal of the College is published quarterly. This journal is circulated to all members and associates and is recognized by general practitioners as being of an informative and readable character. All the contributors are general practitioners, and all the problems discussed in its columns pertain to general practice. Several of the Faculties publish journals of their own with a limited circulation to their own members—the cost of publication being met through the generosity of one of the drug houses.

The Board of Censors advises Council on questions pertaining to applications for membership and associateship of the College. The dates of their meetings are advertised in the *British Medical Journal*.

The Awards Committee advises Council on questions of awards, lectureships, honours, regalia and ceremonies.

The Practice Equipment and Premises Committee has been formed to advise on matters relating to practitioners' equipment and premises. A pilot scheme on the best type of lay-out for 4 different types of practice has now been completed, and any members or associates who are interested can obtain plans and advice for the lay-out of new consulting premises. A room has been provided in which to store plans of premises and items of equipment for members who wish to view various plans before deciding on the type of building they require.

The Examination Committee has held several meetings and has shown conclusively that an Examination in General Practice could be established. It is, however, considered that the time is not yet ripe and that, if possible, complete unanimity on the desirability of examination as one means of entry to the College should be attained before the Council introduces an examination. At present, from the reports received by Faculties, it is clear that there is a widespread feeling, particularly in the younger age-group, that the present criteria for membership need strengthening, and that the majority of Faculties in the United Kingdom are in favour of examinations.

SUMMARY

May I summarize the aims and the hopes of this new College:

1. We hope to establish an academic body with the broad educational aim of steadily improving the quality of general practice.
2. To promote the teaching of general practice to undergraduates by general practitioners both by lectures and the student attachment scheme.
3. To promote postgraduate education for general practitioners and to provide symposia on subjects with which the practitioner is in daily contact.
4. To promote research in general practice. Here we have a vast untapped field unknown to the purely scientific research

worker but which can by good team-work yield information which will be of the greatest value in the diagnosis and treatment of disease.

5. To publish in our own Journal original articles by general practitioners.

6. To regain the right of entry to hospital for general practitioners as full members of the staff occupying a definite place in the unit team. The practitioner must of course regard his hospital session as a first call on his time and only doctors with suitable deputizing arrangements could take advantage of a hospital appointment.

7. To improve the status and prestige of the general practitioner.

Our acceptance of membership attests that the member by post-graduate study is keeping pace with modern medicine, for that is essential.

General practice is that branch of our profession which brings the greatest benefits of modern medicine to the broadest cross-section of the public. To every patient we bring some specialized knowledge, and to many patients we bring the only measure of specialist medical care they are ever likely to need. As the consultant brings his skill to treat the small number of critically ill persons, so we, as general practitioners, should strive to increase our ability to keep the great multitude of others from reaching that critical illness.

VERSKUIWINGS IN BEKLEMTONG BY DIE GENEESKUNDIGE ONDERWYS*

H. W. SNYMAN, M.D. (Groningen), *Dekaan, Fakulteit Geneeskunde, Universiteit van Pretoria*

In sy boek *Inleiding tot die Studie van die Eksperimentele Geneeskunde* het Claude Bernard, die beroemde Franse fisioloog van die vorige eeu, gedagtes uitgespreek wat vandag tot die mediese klasiese geskiedenis behoort. Hy het aangesluit by die standpunt en beskouings van 'n ewe beroemde voorganger, Johannes Müller van Berlyn, en het 'n gedagtegang nagelaat wat vandag nog geldig en vrugbaar is.

DIE BETEKENIS VAN ERVARING

In hierdie boek ontleed hy op aangrypende wyse wat nou eintlik ervaring is, wat feite is en wat idees is, en watter verhouding daar tussen hulle bestaan. Hy wys daarop dat elke wetenskaplike 'ontleding' van die natuur 4 verskillende stadia deurloop.

In die eerste stadium maak die mens 'n toevallige waarneming. Indien die waarneming gereedlik by bekende begrippe en samehang inpas, ontstaan geen probleem nie en neig ons om dit te vergeet. Dit kan egter wees dat dit nie pas nie en in die gedagte bly hang. 'n Enkele waarneming van so 'n aard bly vir die wetenskap steriel: Bernard noem dit 'n 'rou faktor'. Daar is vandag nog geen tekort aan dergelike 'rou faktore' op geneeskundige gebied nie. Sulke faktore kan nie bestanddele van die wetenskap of van die menslike wêreld wees nie, maar kan wel werksaam wees as fermente om ons te dwing om ons wêreld om, of uit, te bou—d.w.s. hulle dra by tot ervaring.

In die tweede stadium verwerk die rou faktor in die gees van die waarnemer 'n idee, waardeur die eers onbegrepe en steriele waarneming verstaanbaar word. So het die idee van 'n bensolring en die idee van 'n sitroensuursiklus by von Kekule en by Hans Krebs onderskeidelik, begrip in die chemie gebring vir wat anders net rou faktore was en sou bly.

Dit is egter pas in die derde stadium dat wat net 'n intuïtiewe idee was, nou omgebou word tot wetenskaplike ervaring. Hierdie skielike voorstelling of idee wat by hom ontstaan, verwerk by die natuurwetenskaplike 'n ambivalente instelling. Hy raak enersyds onder die bekoring van sy idee en andersyds in die greep van twyfel of sy voorstelling of idee bewaarheid sal word. Oorheers die bekoring, dan raak hy verlief op sy idee of voorstelling; hy gaan nie oor tot die proefopstelling nie en 'n werklik wetenskaplike ervaring gaan verlore. Dit is daarom noodsaaklik dat die twyfel moet ontstaan, twyfel wat sal dien as spoorslag totdat die idee bewys is. Uit die twyfel sal die eksperimentele denke 'n hipotese opbou, daar word 'n verklaring van die feite aangebied, gepaard met aanwysings hoe om met die feite om te gaan. Idees vertel nie alleen wat ons uit die feite (die rou faktore) kan haal nie maar hoe om daarmee te werk te gaan.

Hierop volg die vierde stadium, die proefopstelling, waarin die voorskrif vir handeling die idee bevestig of nie. Geluk dit, dan is die idee bewys en die hipotese word teorie. Geluk dit nie, is die idee as onjuis bevind en moet na 'n beter voorstelling gesoek word. Wat dus in so 'n proefopstelling getoets word, is nie die feite (die rou faktore) nie, maar die vooropgestelde verklaring of uitleg wat aan die feite gegee word. Die toepassing van die idee en die feite word daarmee ontleed en op die proef gestel.

Volgens Bernard dan bestaan die wêreld van die natuurwetenskaplike, en dus ook van die geneeskundige, uit twee dele—feite en idees. Hier is dit egter betekenisvolle feite; 'n verklaring is aan die feite geheg, en idees aan die feite-beproepte idees. Hieruit leer ons

dat daar geen werklike ervaring bestaan wat nie op 'n idee rus nie, want 'n feit kan pas deur die interpretasie of verklaring wat die idee aan hom verleen, tot 'n feit word wat iets aan ons kan mededeel; dat werklike ervaring wat so op waarneming en eksperiment steun nie 'n metode is om maar net feite te versamel nie, maar om idees te verwerk en te beproef. Hierdie idees maak ons oë oop, hulle leer ons om werklik te sien. Dit is ook die oorspronklike betekenis van die woord *eidevdi*=om te sien. Die idees is die boustof van ons menslike wêreld, 'n wêreld van voorstellings. Selfs die moderne fisici bv. Einstein en Heisenberg, meen dat die natuurwetenskappe ons nooit tot die suiwer objektiewe sin van dinge kan voer nie. As produkte en deel van die natuur bly ons bevange in ons voorstellingswêreld. Die natuurwetenskap oriënteer ons tussen idees, en as maatstaf, of as meganisme, beproef dit in die omgang die toepassing van die uitleg wat ons idee inhou.

So bou ons dan werklik wetenskaplike ervaring, nie op die gladde verloop verkry deur eendlose herhaling van 'n gekondisioneerde refleks nie, maar deur die klein vonk wat tydens die refleks mag ontstaan. So maklik onttaand, wat in wese steeds 'n interessante opdrag kan wees, tot roetinewerk. Die een pneumonie is maar soos die ander, die een operasie is maar soos die ander. Dit beteken in werklikheid dat ons grotendeels op die vlak van die gekondisioneerde refleks handel, en dat ons die geleentheid, wat elke pasiënt as 'n klein individuele uitdaging, bied nie ten volle benut nie. Ten slotte bly immers die siek mens die uitdaging. Die mate van belangstelling wat ons in die siektegeval ontwikkel, ontstaan uit ons verhouding tot, of beter gestel, ons instelling op die bepaalde geval. Dit is immers ons opvatting wat die pasiënt 'interessant' maak. Sodra ons opvatting soggenaamd versadig is deur die soort geval, neem die interessantheid af en word dieselfde soort pasiënt nie meer aantreklik of prikkelend nie.

Hierin lê een van die wesentlike gevare vir 'n juiste instelling as geneesheer, nl. die neiging om meer geïnteresseerd te wees in die siekte as in die siek mens; dit is nie soser hierdie bepaalde persoon wat siek geword het wat ons belangstelling gaande maak nie, maar die 'interessante' siekte wat hy toevallig herberg. Dit is dus behoefte om ons benadering steeds so in te stel dat elke pasiënt kan dien om 'n vonk of idee te verwerk. Hierdie vonk of idee word vasgehou en oorweeg, dit bekoor ons, ons verbreek die ban van die bekoring om ons eie-geborene bloot te stel aan die harde werklikheid van die proef deur die kritiese verstand. Die vonk is vatbaarste by fyn ingestelde geestelike aanvoeling en by weetgierigheid wat op hulle beurt skerp en wakker is wanneer ons as geneesheer t.o.v. die basiese feite van ons studie-objek, goed georiënteer is. Die juiste geesteshouding en die korrekte basiese kennis is nodig.

BASIESE VAKKE

Die vonke of idees oor ons pasiënte sal des te gereedliker en rykliker ontstaan hoe beter ons hierdie organisme, hierdie besondere en eienaardige skepsel, ons pasiënt, in sy ingewikkelde samestelling ken. Dit is om hierdie rede dat vandag al hoe meer aandag aan die basiese vakke gegee word. Anatomie en fisiologie, die bou en die funksie, hou ten slotte vir ons die geheime in van hoe ons pasiënte kan reageer. Sulke kennis stel ons in die vermoë om siekte vroeër vas te stel en in sy ingewikkelde samehang te volg. Daarom word daarop ook soveel klem gelê in die opleiding van die spesialis en word van hom vereis dat hy weereens hierdie vakke grondig moet bestudeer.

Die kliniese toepassing van hierdie kennis is 'n kuns en 'n tegniek,

* Voordrag gelewer voor die Tak Oranje-Vrystaat en Basoetoland van die Mediese Vereniging van Suid-Afrika te Bloemfontein, 23 Augustus 1958.

'n fyn individuele instelling van beproefde idees; die penwortels van die kennis egter gaan terug na die basiese vakke. Tans word getrag om anatomie te doseer as 'n rangskikking van lewende organe, hoe hulle aanmeekaar verknop is en saam funksioneer; hoe hulle saam groei. Daar word meer geleer oor die samestelling van die weefsels, hoe hulle in die embrio ontstaan en hoe hulle op prikkels reageer. Selfs in die patologiese anatomie verskuif die klem weg van die struktuurbeeld hetsy makro- hetsy mikroskopies, en meer na die histochemiese benadering waarin die veranderende biochemiese samestelling van die aangetaste weefsel deur kleurmodes nagespeur word.

Hierdie nuwe wendings wentel steeds meer om die funksie, die fisiologie, van die orgaan, maar veral van die gehele mens: die fisies-chemiese somatiese struktuur en die nog onmeetbare medespeler, die psige. Die moderne geneeskunde kom telkens hierna terug vir begrip, ons voorstelling van die gesonde en van die siek mens; daardie idees wat oor hom ontstaan word grootliks bepaal deur die omvang van ons kennis van sy normale funksie. Dit het al spreekwoordelik geword om te beweer: die fisiologie van vandag is die interne geneeskunde van môre.

ETIOLOGIE VAN SIEKTE

'n Tweede groot verskuiwing van klem sien ons in nuwere begrippe van die ontstaan van siekte. Die bakteriologiese ontdekkings van die afgelope 80 jaar of meer het aanvanklik die monistiese benadering meegebring waarin een besondere oorsaak vir elke siekte veronderstel is. Dieselfde voortgesette ondersoek, saam met ander benaderings, bring in ons tyd 'n ander gesigspunt. Die etiologiese eenvoud het plek gemaak vir etiologiese meervoud waarin die samespel van etlike faktore gesien en aan ieder 'n waardebeepaling erken word. 'n Kwarteeu gelede is ons studente geskool met die gedagtegang dat 'n siekte, 'n oorsaak het en verder dat ons steeds moes trag om al die siekteverskynsels onder een diagnose te bring. Vandag bring ons veranderde pasiëntebeeld 'n verskuiwing van klem en word geleer dat die mono-etilogie neig tot poli-etilogie, en dat die idee van mono-patologiese proses vervang moet word deur een van multiële of meervoudige siekteprosesse. Ook in die psigiatrie is dit selde moontlik om een spesifieke endo- of eksogene oorsaak aan te dui; verskeie min of meer gelykwaardige elemente moet saamspeel om 'n psigose te veroorsaak.

Hierdie gedagtegang van 'n komplekse etiologie, wat 'n kort stellasië van faktore veronderstel, is reeds vandag die uitgangspunt by siekteoestande soos die rumatiese proses, die neoplasie, leukemie en andere. In leukemie, byvoorbeeld, stel Ludwig Gross wat in die afgelope 4 jaar bekendheid verwerf het vir sy volgehoue werk oor die etiologie van leukemie, die volgende vier essensiële faktore: (1) 'n aangebore vatbaarheid van die gasheer, (2) die aanwesigheid vanaf geboorte van 'n leukemogene agens, (3) 'n aktivator (of versneller) wat intrinsiek of ekstrinsiek kan wees, d.w.s. metaboles of hormonaal in die een geval en fisies of chemies in die ander geval en (4) kondisionerende faktore op die gasheer wat toelaat dat die aktivatore die patogene agens aan die gang sit.

Alhoewel 'n aantal faktore dus gevind kan word wat die siekte in sy verskyning beïnvloed, word nie een van hulle as die primêre beskou nie; nie een wat essensieel die aard van die siekte bepaal nie. Die verskynsels volg op 'n samespel van faktore konstitusioneel,

omgewings en predisponerend, wat elk op sigself beskou aspesifiek is. Die mediese wetenskap moet elke faktor in die samestelling raaksien, dit daaruit isoleer opdat dit geweg kan word t.o.v. die andere meespelende elemente. Pas op hierdie wyse sal ons vorder na 'n wesenlike begrip van hierdie siektes met 'n komplekse etiologie, die siektes waarin veral die endogene komponente 'n groot rol speel, die siektes wat deur ons veranderende pasiëntebeeld die spesiale opdrag geword het van hierdie geslag geneesher.

VOLKSGESONDHEID NA VOORKOMENDE OF PREVENTIEWE GENEESKUNDE

Die beperkte opvatting van volksgesondheid wat ons as studente meegeneem het, tel vandag nie meer as harde munt nie. Die benadering wat oorspronklik ten grondslag van hierdie vak gelê het, is nog die juiste en geldige, maar ook hier het die klem verskuif en word die preventiewe benadering naas die kuratiewe tot in al die vakke ingedra. Selfs in die basiese vakke kan hierdie benadering al toegepas word alhoewel dit pas sy volle invloed in die verhouding van mens-omgewing ontwikkel. Besin ons vir 'n oomblik oor die einddoel van ons beroep, dan is die kuratiewe sukses nie die voleinding van ons strewe nie en kan ons selfs nie oormatig trots daarby stilstaan nie, al sou die sukses hoe daverend wees. Wie gaan voldaan voel met die behandeling van buiktifus of difterie by sy eie kind? Ons sal onself in die stilte verwyt dat ons dit nie voorkom het nie. Hierdie is geen nuwe benadering nie, nie 'n ontdekking van hierdie geslag nie, net 'n juister beklemtoning van 'n uiters belangrike einddoel—die voorkoming van siekte.

'Advies by voorbaat' is eintlik die idee. In hierdie benadering word die verloop van 'n siekte gesien as 'n proses wat op verskeie vlakke van ontwikkeling afgeweer, onderbreek of vertraag kan word:

1. Voór die ontstaan, die prepatogenese—deur bevordering van gesondheid—daarom vandag die benaming departement Voorkomende en Bevorderende Geneeskunde i.p.v. Volksgesondheid.
2. Vroeë patogenese—spesifieke beskerming bv. inenting of profilaktiese behandeling.
3. Vroeë siekte—deur vroeë diagnose en onmiddellike behandeling.
4. Gevorderde siekte—deur beperking van komplikasies.
5. Herstelfase—deur revalidasie of rehabilitasie om die persoon funksioneel vir homself en die gemeenskap so diensbaar moontlik te hou.

Dit is veral punte 1, 2 en 5 wat vandag spesiale aandag verg en vandag die uitgangspunt vorm, soms vir nuwe departemente, sekerlik vir nuwe afdelings of klinieke en soms selfs ook vir nuwe en ongelukkig dikwels verwarrende terminologie.

In die voorafgaande word 'n paar verskuiwings in beklemtoning by die geneeskundige onderwys aangestip. Ek mag herhaal dat hierdie nie nuwe gedagtes of opvattinge is nie, aangesien die vorige geslag geneesher, altns die beses onder hulle, reeds hierdie uitgangspunte geken en toegepas het in hulle praktyk. Hulle het getrag om die gehele mens in sy omgewing te ken. Vandag dwing veranderende vereistes ons om bepaalde aspekte, wat geneig het om verwaarloos te raak, weer onder die oë te sien. Hierdie veranderende vereistes word in hoofsaak geskep deur ons veranderende pasiëntebeeld en die behoeftes wat daaruit voortvloei.

SOUTH AFRICAN MEDICAL AND DENTAL COUNCIL

The *Government Gazette* states that the Minister of Health in exercise of the powers conferred on him by the Medical, Dental and Pharmacy Act 1928 (Act No. 13 of 1928) has appointed the following persons as members of the South African Medical and Dental Council for the period 1 January 1959 to 31 December 1963:

Dr. J. J. du Pré le Roux, L.R.C.P. & S., Edin., L.R.F.P.S., Glas., D.P.H. Univ. W. W. Rand., Chief Health Officer for the Union of South Africa.

Dr. B. P. Pienaar, B.A., M.B., B.Ch., Univ. Dubl., B.A.O., Physician Superintendent, Weskoppies Hospital, Pretoria.

Prof. S. F. Oosthuizen, M.B., Ch.B., M.D., Univ. Cape Town, M., F.R.C.P., Edin., D.M.R. Univ. Lond., F.F.R.

Dr. R. V. Bird, D.D.S. Univ. Mich., Dipl. Mich. State Board.

Dr. J. H. Rauch, M.B., B.Ch., Univ. Dubl., D.P.H., D.T.M.&H., Univ. W. W. Rand.

Adv. J. van Wyk de Vries, B.A., LL.B.

Mr. W. H. Rood.

Dr. C. J. G. Hunter, L.R.C.P. & S., L.R.F.P.S., D.P.H., D.T.M. & H., Medical Officer to the South West Africa Administration.

OFFICIAL ANNOUNCEMENTS : AMPTELIKE AANKONDIGINGS

MEDICAL AID SOCIETIES

The following new Medical Aid Societies were approved by Federal Council at its meeting held in Johannesburg on 1-3 October 1958:

MEDIESE HULPVERENIGINGS

Op sy vergadering van 1-3 Oktober 1958 te Johannesburg gehou, het die Federale Raad onderstaande nuwe Mediese Hulpverenigings goedgekeur:



1. Max Engineering Medical Aid Scheme, P.O. Box 174, Ver-eeniging.
2. Mosenthal's Staff Medical Aid Society, P.O. Box 1, Port Elizabeth.
3. Pilkington Group European Medical Aid Society, P.O. Box 111, Springs, Transvaal.

MEDICAL BENEFIT SOCIETIES WHICH ALLOW FREE CHOICE OF DOCTOR FOR SPECIALIST SERVICES ONLY

1. Brakpan Power Station Sick Benefit Society, P.O. Box 1, Brakpan.
2. Tongaat Sugar Co. Medical Benefit Scheme, P.O. Box 5, Maidstone, Natal.
3. Tweefontein Colliery Employees' Benefit Society, Tweefontein Colliery, P.O. Coalville, Transvaal.

SOCIETIES REMOVED FROM THE LIST

The names of the following Societies have been removed from the list of approved medical aid societies and the members are no longer entitled to the preferential tariff:

1. Hume Cape Medical Benefit Society.
2. C. G. Smith & Co. Ltd. Medical Aid Fund.

Benefit Society in 2nd list:

Anglo-Alpha Roodepoort Benefit Society.

Medical House
35 Wale Street
Cape Town
15 October 1958

L. M. Marchand
Associate Secretary

1. Max Engineering Medical Aid Scheme, Posbus 174, Ver-eeniging.
2. Mosenthal's Staff Medical Aid Society, Posbus 1, Port Elizabeth.
3. Pilkington Group European Medical Aid Society, Posbus 111, Springs, Transvaal.

MEDIESE BYSTANDSVERENIGINGS WAT VRY KEUSE VAN DOKTER ALLEEN VIR SPESIALISTEDIENSTE TOELAAT

1. Brakpan Power Station Sick Benefit Society, Posbus 1, Brakpan.
2. Tongaat Sugar Co. Medical Benefit Scheme, Posbus 5, Maidstone, Natal.
3. Tweefontein Colliery Employees' Benefit Society, Tweefontein Colliery, Pk. Coalville, Transvaal.

VERENIGINGS VAN DIE LYS GESKRAP

Die name van die volgende Verenigings is van die lys van goed-gekeurde mediese hulpverenigings geskrap en lede is nie langer op die voorkeurtarif geregtig nie:

1. Hume Cape Medical Benefit Society.
2. C. G. Smith & Co. Ltd. Medical Aid Fund.

Bystandsfonds in die 2de lys:

Anglo-Alpha Roodepoort Benefit Society.

Mediese Huis
Waalstraat 35
Kaapstad
15 Oktober 1958

L. M. Marchand
Medesekretaris

IN MEMORIAM

ELSIE MARY CHUBB, M.D. (LOND.), D.P.H., R.C.P.S. (ENG.)

Dr. Nico van der Merwe, Medical Inspector of Schools, Cape Education Department, writes: A very remarkable woman and colleague, passed away from our midst, suddenly, on 27 September 1958. She had only just returned from a trip to England, where the meeting of old friends had given her much joy. I had the good fortune and privilege to be closely associated with her for the last 19 years of her life. Her rich experience and outstanding achievements were indeed an inspiration and an encouragement to us in the Cape medical Inspectorate.



Dr. Elsie Chubb

Elsie Mary Chubb was born at Umtata on 26 December 1881, the daughter of a renowned Methodist missionary, the Rev. Theophilus Chubb. She spent her early days on her father's mission stations in the Transkei. He left a deep and abiding impression on her, and laid the foundations of her quite exceptional personality, one in which there was a fine balance of high intelligence and emotional maturity, enriched by a very sincere religious faith. She was a person of warmth and understanding.

She attended the Wesleyan High School at Grahamstown, where her father founded Kingswood College and became its first principal. His interest in education was a further stimulus to Elsie, who wrote towards the end of her life: 'I am always sad that he did not live to see me doing work which combined education with preventative medicine.' After matriculating she attended the Huguenot College at Wellington, and later the South African

College, taking an honours degree, and in 1902 she qualified for the Jamieson scholarship (as did Jessie Spyker); but in those days only men could hold this, and so she was awarded a Porter scholarship for 4 years, instead of 3.

She entered the Royal Free Hospital School of Medicine for Women, London, took her M.B., B.S. degree in 1909, and held hospital posts in maternity and children's hospitals. She proceeded M.D. London in 1911, and then acted as assistant to a woman doctor in a large practice in England. She took the D.P.H. in 1913, went to Berlin for postgraduate work and later the same year was appointed Assistant School M.O. and Assistant M.O.H. for Acton, Middlesex. During World War I she combined this with the hospital work of colleagues in the army.

Dr. Chubb arrived back in South Africa in December 1919, having been appointed Medical Inspector of Schools in the Cape Province together with the late Dr. H. Maughan Brown, after being interviewed by the Hon. W. P. Schreiner, then High Commissioner in London for South Africa. The late Dr. C. Louis Leipoldt was waiting for them in Cape Town; he had been seconded from the Transvaal in May 1919, after the late Dr. Karl Bremer had resigned as the first Medical Inspector of Schools of the Cape Province. After discussions, Dr. Leipoldt handed over and returned to the Transvaal.

The two medical inspectors were faced with the enormous task of organizing and developing the medical inspection of all the school children at schools under School Boards in the Cape Province, at the time numbering 113,000, over a very widely scattered area; as well as of carrying out the actual medical inspections. The onerous inspections and office work were shared by the two medical inspectors. Maughan Brown gradually applied himself more to the mentally backward and physically handicapped children, while Elsie Chubb interested herself more in the various child-welfare organizations, social and church workers, and lecturing at Training Colleges. It was a huge task, and she never spared herself; the travelling was exhausting, transport often uncertain, breakdowns and delays frequent; often it entailed carrying heavy equipment. Accommodation was often uncomfortable, and even primitive, and yet at the end of it all she wrote: 'In spite of the uncertainty and frustration of those crowded early years, there was a fascination about them, and I would not exchange them for the more settled duties of the present time.'

In 1928 she was able to make a study tour of the United States of America. She recorded that at the time it was not legal in the USA to undress children for medical inspection at schools. In South Africa it had been made legal at the inception of the service. During World War II, although already retired, she acted for one of us on the school medical inspectorate who was released for active service. She found the work exciting, and wrote almost despairingly: 'The number of children grows and grows, but the days get no longer.'

After full retirement, her interest in educational matters never flagged, and to the end she was actively interested in the Marsh Memorial Homes. She attended medical meetings regularly, and revealed a keenness of mind and youthfulness of outlook that was always refreshing; indeed, she remained young in spirit to the end.

She has written an unpublished account of the development of the school medical services, which makes fascinating reading, abounding in medical and human interest. It gives generous credit to pioneers like the late Dr. Karl Bremer; she deeply admired his quite amazing achievements as the first medical inspector of schools in a short period of 9 months. Credit goes equally warmly, for example, to the late Sir John Graham, a former chairman of the Cape School Board, Dr. and Mrs. Barnard Fuller, and the Chief Rabbi, Mr. Bender, all powerful supporters of this medical service in its early years. She reveals a sensitive awareness of her environment, and writes about the flowers in Namaqualand one year: 'We motored through flowers of every shade, stretching as far as the eye could see. They ran up kopjes like flames, they clustered in hollows like blue lakes, and rioted everywhere, until we felt dazed with colour and beauty.'

So a life of dedication, in which her work was a real vocation, ended very suddenly. We are glad that she has been spared suffering and invalidism. The great service she helped to initiate and develop will, we hope, grow, and be ever a living memorial to her and her co-workers.

NEIL LIPSCOMB, L.R.C.P. & S. (EDIN.), L.R.F.P.S. (GLASG.)

Dr. J. S. Taylor, of Vryheid, Natal, writes as follows: Dr. Neil Lipscomb, who died here recently, well over 80 years of age, was the last and one of the best of the senior practitioners of Northern Natal. He was a student at St. Bartholomew's Hospital, London and qualified in 1903. He was an English gentleman, a man of fine character, conscientious and able, a very sound physician and an excellent obstetrician.



Dr. N. Lipscomb

Dr. Lipscomb spent nearly all his working life in Paulpietersburg, much of the time single-handed, but always maintained a high level of medical practice. He had little opportunity to travel. He never attended congresses and was little heard of outside the Vryheid District. The late Dr. M. K. Cooper used to remark on the accuracy of his diagnosis when he sent an obscure case into Vryheid Hospital. That was also my

experience. Dr. Lipscomb used sometimes to say that when smallpox occurred in surrounding areas, he kept his district clear.

Angling was his only hobby, so far as I know. He was a keen and skilful fisherman.

Dr. Lipscomb was unmarried. In his old age he refused homes offered by several former patients, preferring his independence with his rough and ready native servant.

PASSING EVENTS : IN DIE VERBYGAAN

Dr. I. Orr, M.B., B.Ch., Dip. O. & G. (Rand) has commenced practice as a specialist Obstetrician and Gynaecologist at 506 Medical Arts Building, 220 Jeppe Street, Johannesburg. Telephones: Rooms 22-0035, residence 44-5001 and emergency 22-4191.

Dr. Johan Jacobs, M.B., Ch.B. (Kapaad), M.Med.Chir. (Pretoria), vroeër van Frankfort, O.V.S., en later van die Algemene Hospitaal, Pretoria, is terug van 'n studiereis in die V.S.A., Engeland en die Kontinent en is tans in plek van Dr. B. Dreyer, wat op die oomblik in Amerika is, werksaam as voltydse chirurg by die Karl Bremer-Hospitaal, Bellville, Kaap.

The South African Paediatric Association. A meeting of the Cape Town sub-Group of this Association will be held on Tuesday 4 November 1958 in the Lecture Theatre, Red Cross War Memorial Children's Hospital, Rondebosch, Cape, at 8.15 p.m. Dr. R. McDonald will give the past-Chairman's address. The title of this address will be 'They Cared for Children—A Short History of Paediatrics'. Dr. S. C. Shore will submit a report of the annual meeting of the South African Paediatric Association.

The Thirteenth Annual Symposium on Fundamental Cancer Research will be held at The University of Texas M.D. Anderson Hospital and Tumor Institute, Houston, Texas, on 26-28 February 1959. The title of the symposium is 'Genetics and Cancer'. It will comprise numerous articles on different subjects under the following general headings: Fundamental aspects of genetics in carcinogenesis; Gene interaction in neoplastic growth; Genetic basis of cell resistance; Heredity and human cancer. Further information may be obtained from the Editorial Office, The University of Texas M.D. Anderson Hospital and Tumor Institute, Houston, Texas, USA.

First Drennan Lecture. The first in the series of Drennan Lectures, under the sponsorship of the M. R. Drennan Fund, University of Cape Town, will be delivered by Dr. Joseph S. Weiner, M.Sc.

(Rand), M.A. (Oxf.), Ph.D. (Lond.), M.R.C.S., L.R.C.P., Reader in Physical Anthropology and Assistant Director of the Medical Research Council Unit for Climatic and Working Efficiency in the University of Oxford. The subject of the lecture will be 'The Tropical Origin of Man', and it will take place in the Physiology Lecture Theatre, Medical School, Observatory, Cape Town, on Monday 10 November at 8.15 p.m. This lecture will be open to the public.

International Congress on Plastic Surgery. The British Association of Plastic Surgeons is holding an International Congress in London on 12-17 July 1959. Subjects to be discussed include: Surgery of congenital deformities, Trauma of the face, Surgery of skin cancer, Cosmetic surgery, Industrial injuries to the hand, Anaesthesia in plastic surgery, and Research projects. Detailed information may be obtained from the Organizing Secretary, Mr. David Matthews, O.B.E., M.Ch., F.R.C.S., International Congress on Plastic Surgery, c/o Institute of Child Health, Hospital for Sick Children, Great Ormond Street, London, W.C. 1.

South African Medical and Dental Council Election. The Journal will be glad to publish particulars concerning candidates for election to the South African Medical and Dental Council. Copy should be received at least 10 days before the date intended for publication and should not exceed 250 words in length.

Verkieping van die Suid-Afrikaanse Mediese en Tandheelkundige Raad. Die Tydskrif sal graag besonderhede publiseer aangaande kandidaat vir verkieping tot die Suid-Afrikaanse Mediese en Tandheelkundige Raad. Kopie hiervoor moet ontvang word ten minste 10 dae voor die voorgestelde datum van publikasie en moet nie meer as 250 woorde beslaan nie.

Union of South Africa, Department of Health. Newsletter No. 41 of 1958. Notification of formidable epidemic diseases and poliomyelitis in the Union during the period 3-9 October 1958.

Plague, Smallpox, Typhus Fever. Nil.

	Poliomyelitis				
	Eur.	Nat.	Col.	As.	Total
Transvaal ..	2	1	—	—	3
Cape Province ..	—	4	2	—	6
Orange Free State ..	1	1	—	—	2
Natal ..	1	2	—	—	3
Totals ..	4	8	2	—	14

Local Authorities		Eur.		Non-Eur.	
Transvaal:					
Boksburg municipality ..	U	1			
Germiston municipality ..	U			1	
Johannesburg municipality ..	U	1			
Cape Province:					
Albany divisional council ..	R			1	
Bathurst divisional council ..	R			1	
Cape Town municipality ..	U			1	
East London municipality ..	U			1	
Herbert divisional council ..	R			1	
Port Elizabeth municipality ..	U			1	
Orange Free State:					
Henneman district ..	R			1	
Rouxville district ..	R	1			
Natal:					
Dannhauser district ..	R			1	
Durban Borough ..	U	1			
Mahlabatini district ..	R			1	

R=Rural. U=Urban.

Unie van Suid-Afrika, Departement van Gesondheid. Nuusbrief nr. 42 van 1958. Opgawes van gedugte epidemiese siektes en

poliomiëlitis in die Unie gedurende die tydperk 10-16 Oktober 1958.

Pes, Pockies. Geen.
Tifuskoors. Kaapprovinsie. 4 (Vier) Naturellegevalle van tifuskoors, insluitende 1 (een) sterfgeval aangemeld uit die distrik Glen Grey.

	Poliomiëlitis			
	Bl.	Nat.	Kl.	As.
Transvaal ..	—	1	—	—
Oranje-Vrystaat ..	1	3	—	—
Natal ..	1	1	—	—
Totaal ..	2	5	—	—

Korreksie:

Kaaprovinsie: 1 (Een) Naturellegeval uit Kaaprovinsie wat in Nuusbrief nr. 40 van 1958 vermeld is, word nou gediagnoseer as 'nie poliomiëlitis'.

Plaaslike Besture		Bl.	Nat.
Transvaal:			
Germiston-munisipaliteit ..	S		1
Oranje-Vrystaat:			
Brandfort-distrik ..	P		2
Excelsior-distrik ..	P	1	
Steynsrus-distrik ..	P		1
Natal:			
Durban-munisipaliteit ..	S		1
Kloof-dorpsgebied ..	S	1	

Korreksie:

Kaaprovinsie: 1 (Een) Nie-blanke geval uit Port Elizabeth-munisipaliteit wat in Bylae tot Nuusbrief nr. 40 van 1958 vermeld is, word nou gediagnoseer as 'nie-poliomiëlitis'.

P=Platteland. S=Stedelik.

REVIEWS OF BOOKS : BOEKRESENSIES

MEDIËSE GESKIEDENIS

A History of Medicine in South Africa. Deur E. H. Burrows, M.B., Ch.B. Pp. 390. Afbeeldings. Landkaart. 63s. (25s. vir lede van die Mediese Vereniging van Suid-Afrika). Kaapstad en Amsterdam: A. A. Balkema. 1958.

Hierdie boek, wat onder die beskerming van die Mediese Vereniging van Suid-Afrika uitgegee is, kan beskou word as die amptelike geskiedenis van die medisyne in Suid-Afrika. Dit is die eerste volledige beskrywing van die geskiedkundige ontwikkeling van die geneeskundige praktyk in ons land. Maar, dit is veel meer as net die geskiedenis van die medisyne. Dit is 'n boeiende, dramatiese en ryk-gekekende verhaal van interessante aspekte uit die geskiedenis van Suid-Afrika. Dit is 'n lywige boek wat 18 hoofstukke, 390 bladsye, 32 illustrasies en baie landkaarte beslaan; daarby is dit deeglik gedokumenteerd en met wetenskaplike presiesheid versorg.

Dit begin met die uitmuntende karakteristiek van die geneeskunde in die 17e eeu. Daar is realistiese beskrywings van die tekortsiektes wat die bemanning van die 17e eeu se skepe aangetas het. Die oprigting van die eerste hospitaal aan die Kaap word beskryf en dan word die fasinierende verhaal verder vertel van die stryd teen siekte en swak gesondheid onder die bewind van die Hollands-Oos-Indiese Kompanjie, die eerste Britse bewind, die Betaafse Republiek, die tweede Britse bewind, die Groot Trek, die Britse Setlaars, die latere Republieke, ens. Die laaste hoofstuk in die boek handel oor die opkoms van die georganiseerde Mediese Vereniging in Suid-Afrika.

Dokters en lekelesers sal die 200 biografiese sketse van chirurgie en geneesheren en bekende geskiedkundige persoonlikhede besonder interessant vind. Die boek is opwindend en kleurrik soos 'n historiese roman. Dit is 'n merkwaardige boek wat 'n waardevolle toevoeging tot enige private biblioteek sal wees.

A.P.B.

ENDOCRINE ASPECTS OF BREAST CANCER

Endocrine Aspects of Breast Cancer. Proceedings of a Conference held at the University of Glasgow, 8 to 10 July 1957. Edited by Alastair R. Currie, B.Sc., M.B., F.R.C.P. (Ed.).

Pp. xvi+340. Illustrations. 37s. 6d.+1s. 5d. Postage Abroad Edinburgh and London: E. & S. Livingstone Ltd. 1958.

This book includes the papers given and summarizes the discussions which took place at a conference in Glasgow in 1957. The reports are not *verbatim*, but strictly edited in the older style. There is no doubt that anyone wanting to know where we stand at the moment with regard to the endocrines and cancer of the breast should read this book, while I would go so far as to say that anyone who actually treats patients with this cancer must read this book if he wishes to know what he is doing. The fact is that having read it, it appears that we really know less about the problem than we thought we did a few years ago.

We learn, for instance, that we cannot totally hypophysectomize a person and that whether we do or not probably little affects the results obtained. In any case, Muller clearly describes a supernumerary pharyngeal pituitary with apparent secreting cells. Further, it appears quite impossible to say at the present day whether any tumour is hormone-independent or even if it ever can be hormone-independent. Regrettably, it appears that Hadfield's nice method of assaying mammatrophic hormone in urine is highly suspect. We come to no conclusion as to the relative values of adrenalectomy and hypophysectomy. Illingworth calls endocrine treatment methods 'superb palliation', but this reviewer does not believe they have earned such praise. Despite detailed discussions by several different authors on several topics, the use of androgens or adrenal cortical hormones, are not considered.

By all means let us read this book—but quickly; it will be out of date in 2 years' time.

W.P.U.J.

TEXT-BOOK OF GYNAECOLOGY

Textbook of Gynaecology. 2nd Edition. By John I. Brewer, B.S., M.D., Ph.D. Pp. xx+742. 204 Illustrations. 120s. net. London: Baillière, Tindall and Cox, Ltd. 1958.

After a lapse of 5 years the second edition of Brewer's *Text-Book of Gynaecology* makes its re-appearance, not only incorporating recent medical advances in this field, but at the same time keeping the book abreast of the constantly changing trends of medical education.

What a pity that this excellent treatise should be so expensive!

One feels sure that it would rank as one of the best sellers but for the reason that it is beyond the pocket of the medical student.

Unlike many other text-books there is very little superfluous subject matter. Brewer's Gynaecology is brief and to the point despite the fact that much new material has been added. Treatment is comprehensive and not overburdening. Reference to the literature augments several of the subjects—subjects which are presented from the standpoint of symptomatology such as dysmenorrhoea, dyspareunia, amenorrhoea and uterine bleeding, progressing to findings and diagnosis with treatment of the ailment producing the trouble. Entities such as malignancy, fibroids, etc., are discussed in detail without unnecessarily dwelling on intricate theories of causation.

The subjects mentioned in this edition are divided into 2 main parts; the first dealing with gynaecology of childhood, maturity and menopause, the second with entities. Carcinoma of the cervix and endometriosis have been almost completely rewritten with the most modern concepts on pathology and treatment. A special chapter on endocrinology has been contributed which is of great interest, particularly in relation to the steroids. Photographs are beautifully depicted and presented with excellent clarity.

Dr. Brewer is to be congratulated for again bringing to our notice this most modern gynaecological text-book. To those who can afford it one must merely say, 'get it'.

L.R.

CORRESPONDENCE : BRIEWERUBRIEK

THE MEDICAL COUNCIL ELECTION

To the Editor: So a knight in rusty armour has lumbered into our *Correspondence Columns*¹ to champion the cause of the inarticulate little man, largely by the clanking of medals.

In passing, I have no hesitation in endorsing Dr. Jonathan Gluckman's timely reminder that the conduct of members of the Medical Council is something of which the profession may take cognizance. Dr. Lance Impey's undignified electioneering outburst, before the present Council had even drawn its last breath, deserved an appropriate reprimand, which he duly received.

I have, however, been impelled to write this letter largely because of Dr. Helman's murderous assault upon classical usage. On behalf of an author² who can no longer speak for himself, I must remind Dr. Helman that the phrase is not *Experientia Docit* but *Experientia Docet*. Even Mrs. Micawber knew about *Experientia*.³

In case Dr. Helman should be exercised about why I was 'so readily persuaded to put pen to paper', let me assure him that the impetus was derived either from your editorial mangling or his own literary inelegancies. In these matters I would urge him to proceed *ex abundanti cautela*.

H. A. Shapiro

P.O. Box 1010
Johannesburg
12 September 1958

1. Helman, M. (1958): S. Afr. Med. J., 32, 304.
2. Tacitus, *History*, Bk. V, Chapter 6.
3. *David Copperfield*. By Charles Dickens, Chapter 11.

RELAXANT DRUGS AND CONSCIOUSNESS

To the Editor: In view of the unimpressive criticism of my article¹ by Dr. Barlow of Johannesburg and Dr. Russell² of Port Elizabeth,* may I quote from Nosworthy's article,³ which was the Frederic Hewitt Lecture delivered at the Royal College of Surgeons of England on 5 December 1957:

'Gone are the days for the need of deep general anaesthesia, but the present danger, in my view, is that anaesthetists may go to the other extreme and omit to anaesthetize some patients at all. It is a sad reflection that one keeps on hearing reports of a paralysed patient being awake during his operation; and even if the patient remembers nothing, it must be disconcerting for the surgeon should he happen to notice him batting an eyelid, or pursing his lips at what is going on!'

Nosworthy then describes the technique which produces this state of paralytic vivisection. Let me continue to quote:

* When Dr. Russell's letter was published on 30 August his address was erroneously printed as being in East London instead of Port Elizabeth.

HAEMATOLOGY

Proceedings of the Sixth International Congress of the International Society of Hematology. Boston, August 27—September 1, 1956. Prepared and edited by the Publications Committee of the Congress. Chairman: A. Richardson Jones. Pp. xxii+930. Figures and Colour Plates. \$25.00. New York and London: Grune & Stratton, Inc. 1958.

The International Society of Hematology held its 6th congress in Boston, Mass. in September 1956 and this is a report of its 500 or so papers. If all the papers had been printed in full, this book would have been many times its size. The international panel of editions, therefore, selected certain papers for full-length publication, the majority being published only as abstracts.

The abstracts serve little purpose and could readily be omitted. They have previously been published in the handbook which was issued in 1956 for use at the congress. It does little good today for example, to read that 'results will be presented' or that 'factors affecting this or that will be discussed'. Most of these abstracts are too short to be helpful—they were written so that members of the congress could know whether the subject-matter of the paper was of interest to themselves or not, and whether they should listen to its presentation.

'After surprisingly light premedication and minimal thiopentone, it is quite a usual practice for patients just to receive nitrous oxide with a high oxygen content, followed by curare and pulmonary hyperventilation. The advocates of this technique argue that the "harmlessness" of the drugs and method employed must mean that the best is being done for their patients. They put forward that, if a patient is only just unconscious, his natural circulatory control mechanism remains intact, and that an alabaster-like complexion with profuse sweating—should it occur—is of no general import. In fact, they maintain that—provided muscular relaxation is complete and blood loss replaced—surgical stimulation registers no response, and the patients can come to no harm. Such has not been my invariable experience. I have often noted during abdominal operations marked falls in blood pressure, vaso-vagal attacks and cardiac arrest.'

From the above quotation it can be seen that not only is paralytic vivisection a fact and not fiction, occurring overseas as well as here, but that it is also dangerous.

Eric Lurie

201 Osler Chambers
Jeppe Street, Johannesburg
14 October 1958

1. Lurie, E. (1958): Med. Proc., 4, 513.
2. Russell, J. T. (1958): S. Afr. Med. J., 32, 879 (30 August).
3. Nosworthy, M. D. (1958): Anaesthesia, 13, 120.

HUMOUR OR OFFENCE?

To the Editor: 'Wanted a sucker' to join 'two suckers' in a practice within easy reach of Durban—advertisement on page xxxiii of your issue dated 11 October 1958. You, I expect, would be strong in support of its claim to be one of the leading medical publications in South Africa.

I would commend to you a reference you may know of—Roget's *Thesaurus*—where in para. 547 definitions of 'sucker' are given as follows: April fool, laughing stock, simple Simon, flat, mug, greenhorn, fool, puppet, cat's paw, dupe. By publishing this advertisement you presumably acquiesce in recommending to the public a medical man of these qualifications.

Is it not rather humiliating to the medical men who have contributed a particularly interesting series of articles in this issue as well as to the medical profession of South Africa, who have made a particular point of joining the Medical Association of South Africa, of which you proclaim yourself the organ?

E. T. N. Taylor

Hermanus, C.P.
13 October 1958

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